
June 2008

MILITARY PERSONNEL

Army Needs to Better
Enforce Requirements
and Improve Record
Keeping for Soldiers
Whose Medical
Conditions May Call
for Significant Duty
Limitations



Report Documentation Page			<i>Form Approved OMB No. 0704-0188</i>	
<p>Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.</p>				
1. REPORT DATE JUN 2008	2. REPORT TYPE	3. DATES COVERED 00-00-2008 to 00-00-2008		
4. TITLE AND SUBTITLE Military Personnel. Army Needs to Better Enforce Requirements and Improve Record Keeping for Soldiers Whose Medical Conditions May Call for Significant Duty Limitations				
5a. CONTRACT NUMBER				
5b. GRANT NUMBER				
5c. PROGRAM ELEMENT NUMBER				
5d. PROJECT NUMBER				
5e. TASK NUMBER				
5f. WORK UNIT NUMBER				
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) U.S. Government Accountability Office, 441 G Street NW, Washington, DC, 20548				
8. PERFORMING ORGANIZATION REPORT NUMBER				
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				
10. SPONSOR/MONITOR'S ACRONYM(S)				
11. SPONSOR/MONITOR'S REPORT NUMBER(S)				
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited				
13. SUPPLEMENTARY NOTES				
14. ABSTRACT				
15. SUBJECT TERMS				
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 61
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified		
19a. NAME OF RESPONSIBLE PERSON				

Highlights of [GAO-08-546](#), a report to congressional requesters

Why GAO Did This Study

The increasing need for warfighters for the Global War on Terrorism has meant longer and multiple deployments for soldiers. Medical readiness is essential to their performing needed duties, and an impairment that limits a soldier's capacities represents risk to the soldier, the unit, and the mission. Asked to review the Army's compliance with its guidance, GAO examined the extent to which the Army is (1) adhering to its medical and deployment requirements regarding decisions to send soldiers with medical conditions to Iraq and Afghanistan, and (2) deploying soldiers with medical conditions requiring duty limitations, and assigning them to duties suitable for their limitations. GAO reviewed Army guidance, and medical records for those preparing to deploy between April 2006 and March 2007; interviewed Army officials and commanders at Forts Benning, Stewart, and Drum, selected for their high deployment rates; and surveyed deployed soldiers with medical limitations.

What GAO Recommends

The Army needs to take specific measures, such as developing an enforcement mechanism to ensure timely performance of medical board evaluations and enhancing soldiers' and their families' access to an ombudsman, to help safeguard soldiers with medical conditions from being deployed and assigned to duties unsuitable to their medical limitations. In written comments on a draft of the report, DOD concurred with GAO's recommendations.

To view the full product, including the scope and methodology, click on [GAO-08-546](#). For more information, contact Brenda S. Farrell, (202) 512-3604 or farrellb@gao.gov

June 2008

MILITARY PERSONNEL

Army Needs to Better Enforce Requirements and Improve Record Keeping for Soldiers Whose Medical Conditions May Call for Significant Duty Limitations

What GAO Found

Army guidance allows commanders to deploy soldiers with medical conditions requiring duty limitations, subject to certain requirements, but the Army lacks enforcement mechanisms to ensure that all requirements are met, and medical record keeping problems obstruct the Army's visibility over these soldiers' conditions. A soldier diagnosed with an impairment must be given a physical profile form designating numerically the severity of the condition and, if designated 3 or higher (more severe), must be evaluated by a medical board. Commanders must then determine proper duty assignments based on soldiers' profile and commanders' staffing needs. From a random projectable sample, GAO estimates that 3 percent of soldiers from Forts Benning, Stewart, and Drum who had designations of 3 did not receive required board evaluations prior to being deployed to Iraq or Afghanistan for the period studied. In some cases, soldiers were not evaluated because commanders lacked timely access to profiles; in other cases, commanders did not take timely actions. The Army also had problems with retention and completeness of profiles; although guidance requires that approved profiles be retained in soldiers' medical records, 213 profiles were missing from the sample of 685 records reviewed. The Army was not consistent in assigning numerical designations reflecting soldiers' abilities to perform functional activities. GAO estimates from a random projectable sample that 7 percent of soldiers from these three installations had profiles indicating their inability to perform certain functional activities, yet carrying numerical designators below 3. While medical providers can "upgrade" numerical designations discretionarily based on knowledge of soldiers' conditions, the upgrades can mask limitations and cause commanders to deploy soldiers without needed board evaluations. While GAO found no evidence of widespread revision in profile designations, some soldiers interviewed or surveyed disagreed with their designations yet were reluctant to express concerns for fear of prejudicial treatment. The Army has instituted a program to provide ombudsmen to whom soldiers can bring medical concerns, but it is targeted at returning soldiers and is not well publicized as a resource for all soldiers with medical conditions. Without timely board evaluations and retention of profile information for deploying soldiers with medical conditions, the Army lacks full visibility and commanders must make medical readiness, deployment, and duty assignment decisions without being fully informed of soldiers' medical limitations.

GAO estimates that about 10 percent of soldiers with medical conditions that could require duty limitations were deployed from the three installations, but survey response was too limited to enable GAO to project the extent to which they were assigned to suitable duties. Along with interviews, however, responses suggest that both soldiers and commanders believe soldiers are generally assigned to duties that accommodate their medical conditions. Occasional exceptions have occurred when a profile did not reflect all necessary medical information or a soldier's special skill was difficult to replace. Officials said soldiers sometimes underestimate their conditions to be deployed with their units, or overstate them to avoid deployment.

Contents

Letter		1
Results in Brief		5
Background		8
Army Is Not Meeting All Requirements for Deploying Soldiers with Medical Conditions and Has Unresolved Problems with Medical Record Keeping		14
Army Requirements for Deploying Soldiers with Medical Conditions Are Not Always Being Met		15
Soldiers' Medical Records Are Not Always Complete and Do Not Always Retain Profiles, and Numerical Designations Are Not Consistently Determined		19
One In 10 Soldiers in the Projectable Sample Who Has a Medical Condition Has Deployed, but We Were Unable to Determine Duty Suitability		25
Some Deploying Soldiers Have Medical Conditions		25
Extent to Which Commanders Assigned Soldiers to Duties Suitable to Their Medical Conditions Cannot Be Determined		29
Conclusions		31
Recommendations for Executive Action		32
Agency Comments and Our Evaluation		32
Appendix I	Scope and Methodology	35
Appendix II	Army Physical Profile (DA Form 3349)	40
Appendix III	PULHES Definitions	42
Appendix IV	Army Physical Profile Codes	43
Appendix V	Department of Defense Pre-Deployment Health Assessment (DD Form 2795)	46

Appendix VI	Comments from the Department of Defense	48
Appendix VII	GAO Contact and Staff Acknowledgments	53
Related GAO Products		54

Tables

Table 1: Number of Soldiers in the Sample with Permanent Physical Profile Designations of 3 Who Did Not Receive Pre-Deployment Evaluation by MMRB or MEB	18
Table 2: Numbers and Percentages of Medical Conditions That May Require Significant Duty Limitations, by Physical Profile Category, across Profiles of Deployed Soldiers in the Sample	28
Table 3: Soldier Sample Universe, Target Sample Sizes, and Number of Records Reviewed at Each Visited Installation	37

Figures

Figure 1: Estimated Percentage of Soldiers with Physical Profile Designations of Permanent 3 Who Deployed and Percentage of Soldiers Who Did Not Receive Pre-Deployment Evaluation by MMRB or MEB	17
Figure 2: Estimated Percentage of Soldiers Unable to Perform Functional Activities Yet Designated as 2 in Their Profiles	21
Figure 3: Comparison of Estimated Percentages of Soldiers with Profiles Who May Require Significant Duty Limitations against Those Who Do Not	26
Figure 4: Comparison of Estimated Percentages of Soldiers Having Medical Conditions That May Require Significant Duty Limitations Who Deployed against Those Who Did Not	27

Abbreviations

AHLTA	Armed Forces Health Longitudinal Technology Application
DOD	Department of Defense
MEB	Medical Evaluation Board
MEDPROS	Army Medical Protection System
MMRB	Military Occupational Specialty Medical Retention Board
MOS	Military Occupational Specialty

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



**United States Government Accountability Office
Washington, DC 20548**

June 10, 2008

The Honorable Ike Skelton
Chairman
Committee on Armed Services
House of Representatives

The Honorable Susan A. Davis
Chairwoman
Subcommittee on Military Personnel
Committee on Armed Services
House of Representatives

The Honorable Vic Snyder
Member of Congress
House of Representatives

From fiscal years 2004 through 2007, the average number of active and reserve servicemembers deployed by the Department of Defense (DOD) has increased about 19 percent, from 216,000 to 256,000 servicemembers, in support of Operation Iraqi Freedom and the Global War on Terrorism. The Army has been the major source of servicemembers supporting continued operations, and the increasing need for able warfighters has meant longer and multiple deployments for its soldiers. Serving in the armed forces requires the medical readiness necessary to plan and execute duties to meet operational goals. Any medical or psychological condition that limits the ability of a servicemember to execute his or her duties represents a risk to the servicemember, the unit, and the accomplishment of the mission. Military commanders, medical providers, and servicemembers share the responsibility for medical readiness as an integrated effort to ensure that servicemembers are ready to fight in support of ongoing operations.

Whenever a soldier is diagnosed with a medical condition, Army guidance requires that medical providers document the soldier's limitations in his or her medical record with a permanent or temporary physical profile.¹

¹See appendix II for a copy of the physical profile form DA 3349.

describing the soldier's medical condition and physical capability. These medical providers, who serve as the profiling officers, must also assign a numerical designation reflecting the extent of any limitation on a scale from 1 to 4, such that a designation of 1 indicates that a soldier has a high level of medical fitness, while a designation of 4 signifies a drastically limited ability to perform military duties due to one or more medical conditions or defects.² A designation of 3 indicates that a soldier has one or more medical conditions that may require significant duty limitations, and the soldier should receive duty assignments that are commensurate with his or her limitations. Once soldiers receive a permanent profile indicating that they have a permanent or chronic medical condition that may require significant limitations in assignment, Army guidance generally requires further evaluation of the soldiers' ability to perform duties in their current job assignments. Moreover, DOD guidance requires soldiers to be evaluated for medical readiness prior to deployment.

In prior reports, we have highlighted long-standing issues with the medical deployability of servicemembers.³ Specifically, we have found continuing problems with the completion of pre- and post-deployment health assessments. We also reported in October 2005 that we found reserve component servicemembers were deploying with preexisting medical conditions, and we provided various recommendations for more guidance and better visibility over servicemembers with medical conditions in theater.⁴ DOD has taken action based on these recommendations, such as establishing tracking and reporting of key force health protection and quality assurance elements such as immunizations and pre- and post-deployment health assessments.

²See appendix III for descriptions of the physical profile numerical designations and categories.

³GAO, *Defense Health Care: Comprehensive Oversight Framework Needed to Help Ensure Effective Implementation of a Deployment Health Quality Assurance Program*, GAO-07-831 (Washington, D.C.: June 22, 2007); *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance*, GAO-03-1041 (Washington, D.C.: Sept. 19, 2003); and *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards*, GAO/NSIAD-94-36 (Washington, D.C.: Mar. 23, 1994). See the Related GAO Products section for more GAO reports pertaining to medical deployability.

⁴GAO, *Military Personnel: Top Management Attention Is Needed to Address Long-standing Problems with Determining Medical and Physical Fitness of the Reserve Force*, GAO-06-105 (Washington, D.C.: Oct. 27, 2005).

From March through October 2007, the Army Office of the Inspector General conducted an inquiry at Fort Benning based on media allegations that soldiers were deployed with significant medical limitations. Army Inspector General officials interviewed the soldiers named in the news articles, numerous medical providers, and unit leaders to obtain their testimonies regarding their pre-deployment medical reviews. The Inspector General officials reviewed the standards for completing physical profiles, the compliance with these standards, commanders' decisions or actions that were based on these profiles, and whether any reprisals may have occurred against soldiers with regard to complaints and concluded that the Army followed standards in all but one instance where a soldier's profile was changed without proper authority and the soldier deployed. The soldier was reevaluated in theater and redeployed to Fort Benning. They found no instances of reprisal. According to an Inspector General official, further investigation of one medical provider led to no findings of wrongdoing. The report recommended that the Army direct (1) a special inspection of medical fitness procedures, which is ongoing; (2) leaders and soldiers to review and follow Army standards for documenting and assessing medical limitations; and (3) the Army Surgeon General to revise the physical profile form to include a Privacy Act statement, instructions for using the physical profile form, and definitions of key terms.

The Chairs of the House Armed Services Committee and the Military Personnel Subcommittee requested that we review the Army's compliance with guidance on the deployment of soldiers with medical conditions.⁵ As agreed with congressional staff, we examined:

1. the extent to which the Army is adhering to its medical and deployment requirements regarding decisions to send soldiers with medical limitations to Iraq and Afghanistan; and
2. the extent to which the Army is deploying soldiers with medical conditions requiring duty limitations to Iraq and Afghanistan, and whether it is assigning them to duties suitable to their limitations.

To address the extent to which the Army is adhering to its medical and deployment requirements regarding decisions to send soldiers with medical limitations to Iraq and Afghanistan, we reviewed Army guidance regarding documentation of soldiers' medical limitations prior to

⁵Representative Vic Snyder was Chair of the Subcommittee on Military Personnel at the time of the request.

deployment and conditions under which soldiers with medical conditions are considered deployable. We selected three Army installations—Fort Benning and Fort Stewart in Georgia, and Fort Drum in New York—that met one or both of the following two factors: (1) these installations had a large number of active component soldiers deployed from each installation to Iraq or Afghanistan between April 1, 2006, and March 31, 2007; or (2) these installations had initial allegations of soldiers being deployed with significant medical limitations from these installations. For these locations, we prepared a random, projectable sample of active component soldiers preparing for deployment who indicated that they may be under a profile. We reviewed medical records of soldiers in this sample and identified a subset of the soldiers who had received profiles documenting medical conditions that may require significant duty limitations prior to preparing to deployment.⁶ We interviewed medical providers, personnel officials, Army commanders, and soldiers to identify and evaluate the installation's procedures for documenting medical limitations in physical profiles and the training provided at each installation. We did not review documentation of medical limitations other than the physical profiles. To determine the extent to which the Army is deploying soldiers with medical conditions requiring duty limitations to Iraq and Afghanistan, and whether it is assigning them to duties suitable to their limitations, we compared the medical data on the subset of soldiers who had significant medical limitations from April 2001 to March 2007 with the soldiers' deployment data from Forts Benning, Stewart, and Drum. From this analysis, we identified the number of soldiers who had a profile in effect at the time of their deployment from each installation. We reviewed Army processes for tracking soldiers while deployed. We interviewed Army officials and commanders about any procedures in place to ensure that soldiers are assigned within their limitations. We also surveyed 66 active component Army soldiers deployed with medical conditions to Iraq and Afghanistan and received responses from 24 of them, for a response rate of about 36 percent. While we cannot project the results of the surveys to all soldiers with medical conditions across the Army deployed to Iraq and Afghanistan, we present the information we obtained to illustrate these issues.

⁶GAO has reported in the past that military health records are often incomplete and do not contain all necessary documentation. GAO, *Defense Health Care: DOD Needs to Improve Force Health Protection and Surveillance Processes*, GAO-04-158T (Washington, D.C.: Oct. 16, 2003); and *Gulf War Illnesses: Research, Clinical Monitoring, and Medical Surveillance*, GAO/T-NSIAD-98-88, (Washington, D.C.: Feb. 5, 1998). Our analysis for this report is considered to be baseline data and cannot be considered comprehensive.

For a complete discussion of our scope and methodology, see appendix I. We conducted this performance audit from April 2007 through April 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

Commanders may deploy soldiers who have medical conditions that may require significant limitations in duty assignment, subject to certain requirements; however, the Army lacks enforcement mechanisms to ensure that all requirements are met, and various other problems exist with regard to record keeping of physical profiles. Based on a random projectable sample of soldiers preparing to deploy during April 2006 through March 2007, we estimate that 3 percent⁷ of soldiers from Fort Benning, Fort Stewart, and Fort Drum who met the criteria for higher evaluation by a medical board did not receive needed evaluations prior to being deployed to Iraq or Afghanistan. Army guidance requires a soldier diagnosed with a limiting medical condition to be given a physical profile indicating the severity of the limitation, and in certain cases, to be reviewed by a Military Occupational Specialty Medical Retention Board (MMRB) or a Medical Evaluation Board (MEB). Commanders, with the assistance of personnel management officers, are responsible for determining proper duty assignments for soldiers based on their knowledge of the soldiers' physical profiles and assignment limitations, and soldier's job duties. According to personnel officials, in some cases soldiers do not receive needed board evaluations prior to deployment because medical officials did not distribute profiles to commanders in a timely way, or because commanders did not take needed action prior to the soldiers' deployments. Without performing required medical board evaluations, the Army lacks a systematic method for ensuring that commanders recognize all cases of medical limitations and assign soldiers to duty assignments that suitably accommodate them. Additionally, the Army continues to have problems with the completeness and retention of physical profiles, and it has been inconsistent in its designations of

⁷All percentage estimates of soldiers at these installations are based on random samples and are subject to sampling error. For this estimate, we are 95 percent confident that between 1 percent and 4 percent of soldiers from these installations did not receive required evaluations prior to deployment.

soldiers' abilities to perform certain functional activities. Once physical profiles are prepared, signed, and approved as needed, Army guidance requires that the physical profiles be retained in soldiers' medical records. At Forts Benning, Stewart, and Drum, we found that 213 physical profiles were missing from the 685 medical records of soldiers with medical conditions that may require significant limitations. Of the physical profiles retained in the sample of these medical records, we determined that 20 profiles were not complete, for example, they lacked necessary approval signatures. We found that each installation uses its own process for retaining physical profiles, leading to inconsistencies in retention across Army installations. The Army intends for all physical profiles to be processed and retained in its official electronic medical record system, in an effort to correct inconsistencies in profile procedures; however, steps have not been taken to implement this change and current plans do not ensure that information will be entered and distributed in a timely manner. Moreover, from the random projectable sample of soldiers preparing to deploy, we estimate that about 7 percent⁸ of soldiers from Forts Benning, Stewart, and Drum had medical records that indicated they could not perform certain functional activities and yet were not designated accordingly. While Army medical providers have some flexibility to upgrade soldiers' numerical designations to indicate less severe medical conditions based on knowledge of the soldiers' medical conditions, these discretionary upgrades can mask soldiers' limitations and cause commanders to deploy soldiers without needed medical board evaluations. While we found no evidence of widespread revision in profile designations, some soldiers told us that they disagreed with the numerical designations they were assigned yet were reluctant to bring their concerns to their commanders for fear of prejudicial treatment. The Army has instituted an ombudsman program to provide a point of contact to whom soldiers and family members can bring their concerns, but the program is targeted at returning rather than deploying injured soldiers, and it is not well publicized as a resource for active duty soldiers with medical conditions.

From our random projectable sample of soldiers preparing for deployment between April 2006 and March 2007, we estimate that about 10 percent⁹ of soldiers from Forts Benning, Stewart, and Drum who have medical conditions that could require significant limitations in duty assignments

⁸The 95 percent confidence interval for this estimate is from 5 to 10 percent of soldiers.

⁹The 95 percent confidence interval for this estimate is from 7 to 12 percent of soldiers.

were deployed to Iraq and Afghanistan, but we were unable to determine whether those soldiers were assigned to duties suitable to their medical conditions. We were told that soldiers, at times, underestimate their conditions or negotiate with medical providers in order to be deployed with their units or to remain in the Army; conversely, in some cases soldiers have overstated their medical conditions in order to avoid deployment. We estimate that about 86 percent of soldiers from the three installations did not have profiles indicating medical conditions that could require significant limitations. Of the estimated 14 percent who had such medical conditions, approximately two-thirds were deployed. Most of the deploying soldiers whose medical records indicated a potential requirement for significant duty limitations had conditions such as herniated discs, various forms of back pain, or chronic knee pain. We could not determine the extent to which the Army assigned soldiers with medical conditions to duties that were suitable to their limitations because of the limited response to our survey. However, our limited survey responses and interviews with soldiers and commanders revealed that most respondents in both surveys and interviews believed soldiers were generally assigned to duties that were suitable to their limitations. We spoke with commanders at Forts Benning, Stewart, and Drum, and they reported that they were aware of the medical conditions of the soldiers with whom they had deployed and always took these conditions into account when assigning duties. Most soldiers whom we interviewed or who responded to our survey revealed that they were able to accomplish most of their duties. For example, one soldier who had back pain limiting his ability to carry all necessary combat equipment reported that he had discussed this problem with his commander while in theater, and the commander had reassigned him to duties that did not require wearing all his equipment. Commanders we interviewed noted that they occasionally required their soldiers to perform duties potentially exceeding the soldiers' medical limitations, in some cases because a soldier's physical profile did not reflect all necessary medical information, or in other cases because the soldier had special skills that were difficult to replace.

We are recommending that the Army take several actions; first, to help ensure that soldiers with medical conditions are appropriately evaluated and assigned to suitable duties while deployed, and second, to help ensure that active duty soldiers and their families have access to a point of contact to whom they can bring concerns regarding recognition of their medical limitations prior to and during deployment. In commenting on a draft of this report, DOD concurred with our recommendations; we summarize these comments and provide our response in our Agency Comments section.

Background

Various pieces of DOD guidance provide overall direction and require the services to define medical deployment standards to ensure that servicemembers deploying to a theater of operations are in optimal health.¹⁰ DOD allows the military services to deploy servicemembers who do not meet the services' medical standards under certain conditions. For example, a service is required to obtain a waiver from the Combatant Command Surgeon if the service wishes to deploy a servicemember who does not meet deployment standards and can receive medical treatment at deployed locations that will render them fit for duty.¹¹ DOD guidance requires the services to continue to employ measures that ensure servicemembers are medically and psychologically fit for worldwide deployability, taking into account additional guidance provided by the combatant commander on theater-specific medical limitations. The Assistant Secretary of Defense for Health Affairs is planning to release new guidance that provides more guidelines on medical conditions that, in general, should preclude servicemembers from being deployed. Because DOD has not determined the issue date and has not yet implemented this new guidance, we were not able to evaluate its effect during our review.

The Offices of the Surgeon General of each military service have established procedures to evaluate the health conditions of their servicemembers according to service-specific medical standards.¹² Our prior work has shown that the Army, Air Force, Navy, and Marine Corps all have different methods of assessing their servicemembers' medical readiness prior to deployment and documenting any medical conditions

¹⁰Under Secretary of Defense for Personnel and Readiness, Department of Defense Instruction 6490.03, *Deployment Health* (Aug. 11, 2006); Under Secretary of Defense for Personnel and Readiness, Memorandum, *Policy Guidance for Medical Deferral Pending Deployment to Theaters of Operation* (Feb. 9, 2006); Under Secretary of Defense for Personnel and Readiness, Department of Defense Instruction 6025.19, *Individual Medical Readiness (IMR)* (Jan. 3, 2006); Under Secretary of Defense for Personnel and Readiness, Department of Defense Instruction 6200.05, *Force Health Protection Quality Assurance Program* (Feb. 16, 2007); Assistant Secretary of Defense, Memorandum, *Policy for Department of Defense Deployment Health Quality Assurance Program* (Jan. 9, 2004); U.S. Central Command, Individual Protection and Individual/Unit Deployment Policy, *PPG Modification 8* (July 2007).

¹¹In our review, we did not find that soldiers in our sample who had deployed were considered not deployable due to their medical condition and thus, we did not find instances of waivers in order to deploy soldiers in our sample.

¹²U.S. Army Regulation 40-501, *Standards of Medical Fitness* (Jan. 18, 2007); U.S. Air Force Instruction 10-203, *Duty Limiting Conditions* (Oct. 25, 2007); and U.S. Navy Manual of the Medical Department NAVMED p-117 (Aug. 12, 2005).

and limitations. The Army's guidance, similar to the other services' guidance, allows the commander to have the ultimate authority to deploy servicemembers and make proper duty assignments, if certain procedures are followed, while taking into account the medical provider's assessment of a servicemember's medical condition and duty limitations.

Army Guidance

The Army Office of the Surgeon General and Army Deputy Chief of Staff (G-1) provide guidance on soldiers' medical readiness. Regarding medical matters, the Army Office of the Surgeon General heads the Army Medical Command, which provides guidance to Army medical treatment facilities. Medical Evaluation Boards (MEB) of soldiers are conducted at medical treatment facilities at Army installations. Regarding command matters, the Army Manpower and Reserve Affairs Office works with the Army Deputy Chief of Staff G-1 to provide guidance to human resource directorates at each installation. The Deputy Chief of Staff G-1 has overall responsibility for the Physical Performance Evaluation System which involves an administrative screening board known as the Military Occupational Specialty Medical Retention Board (MMRB).

Physical Profiles

Army Regulation 40-501 requires that the Army document physical and mental conditions that may limit a soldier's ability to perform his or her duties on the physical profile form. Using the physical profile, Army medical providers, who serve as profiling officers, provide recommendations on a soldier's medical limitations in order to assist the commander in properly assigning the soldier to duties that contribute to the unit's mission. A profiling officer creates a physical profile that documents any limitations found during a medical examination, and identifies whether the medical limitation is temporary, in which case a short-term condition can be improved by further treatment, or permanent, in which case a chronic condition will not improve with medical treatment at that point in time. The profiling officer classifies the medical limitations under six categories:

- physical capacity
- upper extremities
- lower extremities
- hearing
- eyes
- psychiatric

These categories are often abbreviated as the "PULHES" factors (see app. III for further detail). The medical limitations in physical profiles are

also given a numerical designation from 1 to 4 to reflect the different levels of functional capability and severity of impairment. Soldiers with physical profiles designated by the number 1 are considered to have a high level of medical fitness; a 2 indicates that a soldier has some medical condition or physical defect that may require some activity limitations; a 3 under one or more of the factors indicates that the soldier has a medical condition or physical defect that may require significant limitations in duty assignment; and soldiers designated by the number 4 must have their military duties drastically limited.¹³ Profiling officers must also specify whether the soldier can perform certain functional activities comprising the minimum requirements needed in order to be medically qualified for worldwide deployment.

Profiling officers should evaluate a soldier who has a temporary profile at least once every 3 months to determine whether the soldier's medical condition has improved or, if not, whether an extension of up to 12 months is needed. If an extension is needed beyond 12 months, a temporary profile should be changed to a permanent profile. Permanent and temporary profiles normally require the signature of only the profiling officer. Both the signatures of the profiling officer and a higher level medical provider, who is designated the approving authority, are required when a permanent profile number is designated at 3 or 4, or when a permanent profile designation has been changed from a 3 to a 2.

According to profiling officers, during the preparation of the physical profile and medical evaluation of the soldier, the profiling officer may communicate with the commander of the soldier for the purpose of better identifying the soldier's medical limitations. All permanent physical profiles are coded to designate any assignment limitations, including whether a soldier has been reviewed by an MMRB or a Physical Evaluation Board.¹⁴ Once the physical profile is signed by profiling officer, and approved by the designated approving authority as needed, Army regulation 40-501 requires that the completed physical profile should be retained in the soldier's medical record and copies of it should be

¹³During our review at the three installations, we only reviewed one physical profile designated at level 4. It was a temporary profile and the soldier did not deploy with it in effect.

¹⁴Currently, no code exists for soldiers reviewed by an MEB who were not also reviewed by a subsequent Physical Evaluation Board. The Army plans to correct this oversight in the next revision of Army regulation 40-501. See appendix IV for full description of profile codes from AR 40-501.

distributed to the unit commander and the soldier. For permanent physical profiles, one more copy is distributed to the military personnel office.

Army medical records comprise both hard copy documents and an electronic system called the Armed Forces Health Longitudinal Technology Application (AHLTA), the official system for retaining soldiers' medical documentation. AHLTA is used DOD-wide and gives medical providers access to soldiers' medical information, including medical evaluation history, prescriptions, diagnostic tests, and physical profile information. The Army also tracks soldiers' medical readiness information through the Army Medical Protection System (MEDPROS), in order to allow commanders to have access to soldiers' medical information that might affect readiness, but this system retains limited information only on permanent physical profiles and does not supply any detailed description of medical limitations or incapacity to perform functional activities.

MMRB and MEB Evaluations

Because physical profiles merely represent medical recommendations made by the profiling officer to a soldier's commander, physical profile designations do not automatically determine whether a soldier is deployable or not. Three Army regulations require higher levels of review for soldiers with a numerical designation of at least a 3 in order to assist commanders in properly assigning soldiers to duties suitable to their medical limitations.¹⁵ Army guidance states that once soldiers receive a permanent profile designation of at least a 3, they are not deployable for the duration of the MMRB or MEB until the board is concluded.¹⁶

If a soldier receives a permanent profile of at least a 3, the profiling officer and approving authority must provide an initial determination of whether the soldier meets Army medical standards or not.¹⁷ If they believe that a soldier meets medical standards, Army regulation 600-60 requires that the soldier be reviewed by an MMRB to determine whether the soldier is able to complete the duties in his or her job assignment or needs to be reassigned to a job that accommodates his or her limitations. The MMRB

¹⁵ Army Regulation 40-501; Army Regulation 600-60, *Physical Performance Evaluation System* (June 25, 2002); Army Regulation 40-400, *Patient Administration* (Feb. 6, 2008).

¹⁶ Army Regulation 600-60 (June 25, 2002).

¹⁷ Army Regulation 40-501, chapter 3, lists certain diseases or medical conditions that could severely limit a soldier's ability to perform his or her duties, such as heart disease, cirrhosis of the liver, chronic asthma, and epilepsy.

consists of five voting members, including a medical provider, a senior commander, and when reasonably available, soldiers of the same branch or specialty as the soldier being evaluated as well as non-voting members including a personnel advisor, a recorder, and anyone else to ensure a fair hearing. Once the personnel office receives the permanent profile from the medical administrative office and convenes an MMRB, the recorder will assemble the soldier's personnel records and medical records. The commander will prepare an evaluation of the impact of the profile limitations on the soldier's ability to perform the full range of duties in the soldier's job assignment, known as a Military Occupational Specialty (MOS). During the MMRB, the personnel advisor will summarize the details of the soldier's current MOS and common duties, and the medical provider will brief the MMRB on the soldier's physical profile. The soldier will also present facts or call witnesses relevant to his or her physical performance, current MOS retention, or MOS reclassification preference. The MMRB can recommend either that (1) the soldier remain in the Army under his or her current military occupational specialty or specialty code, (2) the soldier be placed in probationary status for up to 6 months to improve the condition of a disease or injury, (3) the soldier be reclassified into another occupational specialty, or (4) the soldier be referred to the MEB for medical disqualification processing.

Active component Army soldiers should appear before an MMRB within 60 days of the date the physical profile is signed by the medical provider who is designated the approval authority. Army regulation 600-60 requires that personnel officials responsible for convening the MMRB maintain statistics on each case in order to assess whether or not MMRB evaluations are convened within the 60-day time limit. As of March 2008, officials now are required to report the statistics to the Deputy Chief of Staff of the Army.

Alternatively, if a profiling officer and the approving authority believe that a soldier with a permanent profile designation of at least a 3 does not meet medical standards, Army regulation 40-501 requires that the soldier should be reviewed by an MEB to fully ascertain the soldier's medical condition and limitations. From the MEB results, a subsequent Physical Evaluation

Board determines whether the soldier is to be retained in the Army or not, and the applicable disability rating.¹⁸

There are two ways in which an MEB is initiated: by referral from the medical provider designated as the approving authority or by referral from an MMRB. When an MEB is referred by an approving authority, the soldier's physical profile is distributed to the Physical Evaluation Board liaison officer at the medical treatment facility, who is responsible for the case management of the soldier. A medical provider reexamines the servicemember and reviews his or her medical history, including prior test results, diagnoses, and treatments. The medical provider will then complete a narrative summary to document the nature and degree of severity of the soldier's condition. The commander also provides a letter describing how the soldier's medical condition affects job performance and deployability status. Also provided is a summary of the soldier's chief complaint, stated in the soldier's own words. MEBs are composed of two or more physicians, one being a senior medical provider with detailed knowledge of Army medical standards and procedures, and other members having familiarity with these matters. MEB evaluations must be completed within 90 days of approval of the physical profile, or of the date when the MMRB referral is received by the liaison officer. The MEB could result in several outcomes, including: (1) the soldier is returned to duty, with a profile marked that he or she meets medical retention standards; or (2) the soldier is referred to a Physical Evaluation Board to determine whether he or she has lost the ability to perform assigned duties because of a medical condition and thus is unfit for duty, or the soldier is fit for duty and thus is retained in the Army.

An Army memorandum requires that the liaison officers track certain statistics and use an electronic database system to ensure that MEB evaluations are completed within 90 days.¹⁹ This information is reported quarterly to the Deputy Under Secretary of Defense for Military Personnel Policy.

¹⁸The MEB and Physical Evaluation Board processes are together called the Physical Disability Evaluation System, but because a soldier is not evaluated by a Physical Evaluation Board without first going through an MEB, we refer to this in the report as the MEB process.

¹⁹Chief of Staff of the United States Army, Memorandum, *Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing* (Sept. 26, 2007).

Pre-deployment Health Assessments

According to a DOD instruction,²⁰ within 60 days prior to deployment, soldiers complete a pre-deployment health assessment form²¹ to reflect soldiers' medical readiness with respect to immunizations, dental, hearing/eye exams, and medical limitations on physical profiles. If a soldier indicates on the pre-deployment health assessment form that he or she is on a profile, or light duty, or undergoing a medical board, the soldier is referred to a medical care provider for reevaluation and verification of the medical limitations under the physical profile. If a soldier does not meet the medical requirements under the pre-deployment health assessment, the soldier is classified as not deployable, until the soldier receives further treatment. Moreover, if a soldier is also undergoing an MMRB or MEB, the soldier is considered not deployable until the evaluation is completed and the soldier is found fit for duty. The pre-deployment health assessment is updated to indicate that the soldier is deployable once he or she receives treatment or undergoes a board screening and is found fit for duty.

Under Army regulation 40-501, Army commanders have the ultimate authority to deploy soldiers, but commanders are required to recognize soldiers' limiting conditions and assign them duties consistent with their limiting conditions, with the assistance of personnel management officers from Army Forces Command and Human Resources Command.

Army Is Not Meeting All Requirements for Deploying Soldiers with Medical Conditions and Has Unresolved Problems with Medical Record Keeping

The Army allows commanders to deploy soldiers who have medical conditions that may require significant limitations in duty assignment as long as they meet requirements in the guidance, including board evaluations, suitable duty assignments, and available medical treatment in deployed locations, if needed; however, the Army is not meeting all requirements to ensure board evaluations are conducted within prescribed time frames, and various problems exist with regard to physical profile record keeping. Army requirements for deploying soldiers with medical conditions are not always being met; commanders are not always aware of medical limitations in a timely way, and in the sample review, we found that commanders are not always adhering to guidance to ensure that soldiers are not being deployed to Iraq or Afghanistan prior to having needed MMRB or in some cases MEB evaluations. Furthermore, the Army continues to have problems with retention and completeness of its

²⁰Department of Defense Instruction 6490.03 (Aug. 11, 2006).

²¹See appendix V for a copy of the pre-deployment assessment form DD 2795.

physical profiles, as well as a lack of consistency in designations with regard to soldiers' abilities to perform functional activities. While we did not find widespread revision of profiles prior to deployment, we found that soldiers were concerned about how the Army was addressing their medical problems prior to deployment. While commanders may recognize medical limitations on a case by case basis, without performing required medical board evaluations, the Army lacks a method for ensuring that all such cases are appropriately recognized.

Army Requirements for Deploying Soldiers with Medical Conditions Are Not Always Being Met

While Army guidance allows commanders to deploy soldiers with medical conditions that may require significant limitations in duty assignments, subject to certain requirements, we found that commanders are not always aware of soldiers' medical limitations when making deployment decisions, and they do not always adhere to these requirements. Army guidance requires that whenever a new physical profile is created, copies of physical profile documentation, once authorized by the approving medical authority, should be added to a soldier's medical record and given to the soldier, his or her commander, and the command's personnel office.²² Army guidance stipulates that soldiers with a permanent profile containing a numerical designation of a 3 or 4 who meet Army medical retention standards should be evaluated by an MMRB within 60 days of receiving the approved physical profile, to determine whether the soldier is able to complete all the duties in his or her current job assignment or should alternatively be reassigned to a job that accommodates his or her medical limitation(s).²³ Alternatively, a soldier with a permanent profile of a 3 or 4 who is believed by a profiling officer not to meet medical standards must be evaluated by an MEB within 90 days to determine whether that soldier should be retained in the Army.²⁴ Moreover, within 60 days prior to deployment, DOD guidance requires the Army to review soldiers for medical readiness.²⁵ During this pre-deployment assessment, soldiers who report having a physical profile must be referred to a medical provider, which according to medical providers may result in an updated confirmation of their numerical designation. If a soldier receives a new profile indicating a medical condition that may require significant

²² Army Regulation 40-501 (Jan. 18, 2007).

²³ Army Regulation 600-60 (June 25, 2002).

²⁴ Army Regulation 40-400 (Feb. 6, 2008).

²⁵ DOD Instruction 6490.03 (Aug. 11, 2006).

limitations in assignment, Army guidance categorizes the soldier as not deployable until he or she is reviewed by an MMRB or in some cases MEB.²⁶ Commanders, with the assistance of personnel management officers, are responsible for determining proper duty assignments for soldiers based on their knowledge of soldiers' physical profiles, assignment limitations, and the need for accomplishing necessary duties within the soldiers' MOS. Commanders may also consider the availability of medical treatment at deployed locations when determining the deployability of soldiers with physical profiles.

At Forts Benning, Stewart, and Drum, we found that commanders are not always adhering to requirements in Army guidance to ensure that needed board evaluations are performed. After reviewing 685 medical records and the deployment information of soldiers who were preparing for deployment in the statistically valid sample, we estimate that 6 percent of soldiers from Forts Benning, Stewart, and Drum were deployed with designations of permanent 3 in their physical profiles—signifying to a commander that they have medical conditions that may require significant limitations.²⁷ These soldiers should have been reviewed prior to deployment by a MMRB, or MEB as needed, in accordance with Army regulations.²⁸ Further, we estimate that about 3 percent of the soldiers from Forts Benning, Stewart, and Drum had profiles that indicated that they met medical retention standards and required an MMRB, or may not meet standards and required an MEB, but were deployed without having been reviewed by an MMRB or MEB.²⁹ Figure 1 summarizes percentages (and confidence intervals) of soldiers with profile designations of permanent 3 who deployed from Forts Benning, Stewart, and Drum, and the percentage of those soldiers who did not receive evaluation by an MMRB or MEB prior to deployment.

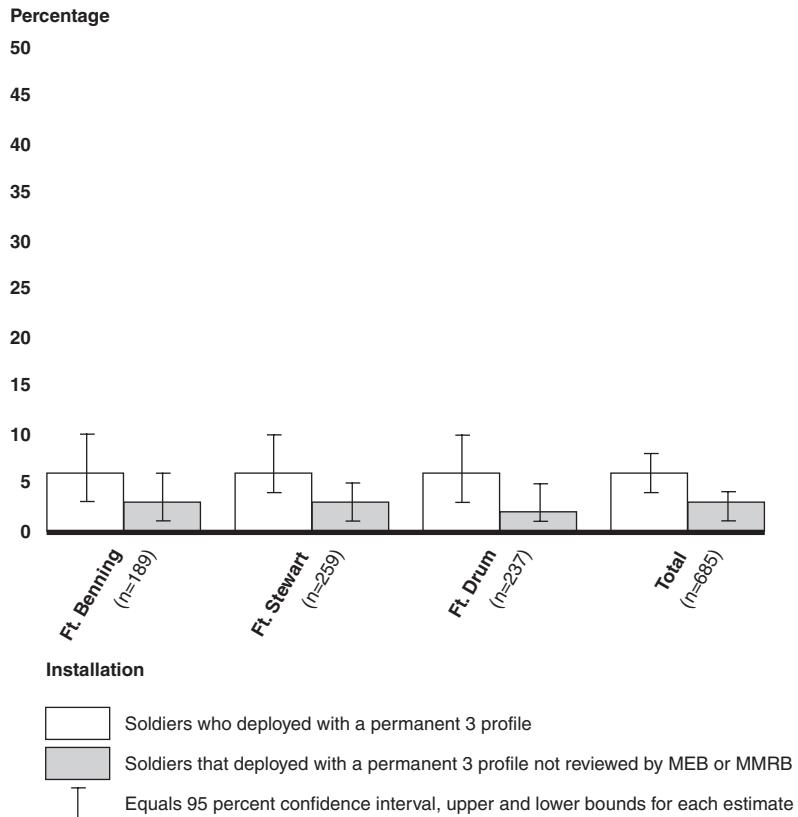
²⁶ Army Regulation 600-60 (June 25, 2002).

²⁷The 95 percent confidence interval for this estimate is from 4 to 8 percent of soldiers.

²⁸Although the Army may obtain a waiver in order to deploy soldiers that do not meet medical fitness standards if medical treatment is available in theater according to DOD guidance, we did not find evidence of any waivers.

²⁹The 95 percent confidence interval for this estimate is from 1 percent to 4 percent of soldiers.

Figure 1: Estimated Percentage of Soldiers with Physical Profile Designations of Permanent 3 Who Deployed and Percentage of Soldiers Who Did Not Receive Pre-Deployment Evaluation by MMRB or MEB



In our sample, we found that of the 42 soldiers who had profile designations of permanent 3, 17 soldiers did not receive needed board evaluations prior to their deployment. Although we could project this as a percentage of the soldiers from Forts Benning, Stewart, and Drum, we did not project this as a percentage of the 42 soldiers who had profile designations of a permanent 3 because the size of this subgroup in the sample is not sufficient to report a reliable confidence interval for a population estimate. Table 1 shows the number of soldiers in the sample with permanent physical designations of 3 who did not receive pre-deployment evaluations by MMRB or MEB.

Table 1: Number of Soldiers in the Sample with Permanent Physical Profile Designations of 3 Who Did Not Receive Pre-Deployment Evaluation by MMRB or MEB

Army installation	Number of soldiers who deployed with permanent profiles of 3	Number of deployed soldiers with permanent profiles of 3 not reviewed by MMRB or MEB
Fort Benning	11	5
Fort Stewart	16	7
Fort Drum	15	5
Total	42	17

Source: GAO analysis of DOD data.

Notes: The size of this subgroup in the sample is not sufficient to report a reliable confidence interval for a population estimate. Therefore, we did not project this subgroup to the population of Forts Benning, Stewart, and Drum. MEB evaluations are conducted in cases where retention is in question.

These needed evaluations may not be occurring because each of the three installations lacked an enforcement mechanism to ensure all procedures are followed. According to medical providers, commanders, and personnel officials, in some cases soldiers do not receive their MMRB or MEB evaluations because profiles were not distributed by the approving authority or medical administrative office in time to inform commanders of the existence of the profiles. In other cases, according to personnel officials, commanders were given notice of the profiles but did not take needed action on time, but we were not able to determine why this occurred.

Moreover, we found that while Army personnel officials at the three installations we visited were maintaining proper data on MEB evaluations, they were not maintaining required statistics on the performance of MMRB evaluations. Army guidance requires that medical and personnel officials have to maintain certain statistics in order to know whether MEB or MMRB evaluations are conducted within set time frames.³⁰ Personnel officials told us that they kept informal data on each MMRB case in separate files, such as the date of the approved profile, the date it was received, and the date of the MMRB. However, this information was not summarized as would be needed in order to calculate the period of time that elapsed between the stages of MMRB evaluations. Prior to February

³⁰ Army regulation 600-60 (June 25, 2002); Chief of Staff of the United States Army, Memorandum (Sept. 26, 2007).

2008, the Army did not require that these statistics be reported to anyone. The Army revised its regulation 600-60 to require the reporting of quarterly statistics to the Deputy Chief of Staff of the Army beginning in March 2008. That change may lead to better oversight of the timeliness of the MMRB, but we were not able to assess the impact of this recent change during this review.

Without performing all required medical board evaluations or tracking the timeliness of board evaluations, the Army lacks a systematic method for confirming that commanders recognize all cases of medical limitations and assign soldiers to duty assignments that suitably accommodate them.

Soldiers' Medical Records Are Not Always Complete and Do Not Always Retain Profiles, and Numerical Designations Are Not Consistently Determined

Medical records are intended to provide a soldier's history of medical treatment and limitations, and Army regulation 40-501 requires that once physical profiles are prepared and signed, the profiles should be kept in a soldier's medical record. These completed profiles include the numerical designation, a description of medical limitations, the signature of the profiling officer and approving authority, as needed, and the dates of the signatures. Medical records comprise both the hard copy and electronic versions of medical information. Commanders use physical profiles to assess soldiers' physical ability to perform their duties.

When we compared records in the official electronic medical system, AHLTA, and hard copy records with those in an electronic medical readiness system, MEDPROS, we found that 213 physical profiles were missing from the 685 medical records of soldiers in the sample who had a medical condition that may require significant limitations at Forts Benning, Stewart, and Drum. Further, of the physical profiles that were retained in the sample of medical records of soldiers with medical conditions that may require significant limitations, we found that 20 were not complete. Specifically, both hardcopy and electronic medical records lacked profiles with the appropriate signatures and dates of final approval.

These problems may be occurring because each installation uses its own informal process for approving and distributing completed physical profiles to the soldier, commander, and medical record. For example, at Forts Benning and Stewart, a profiling officer would consult with the soldier and his commander in creating the profile, and if the physical profile were permanent and designated a 3 or 4, the medical provider who created the profile would provide it to the approving medical provider. The approving medical provider would then provide it to personnel officials in order to initiate an MMRB or to the liaison officer to initiate an

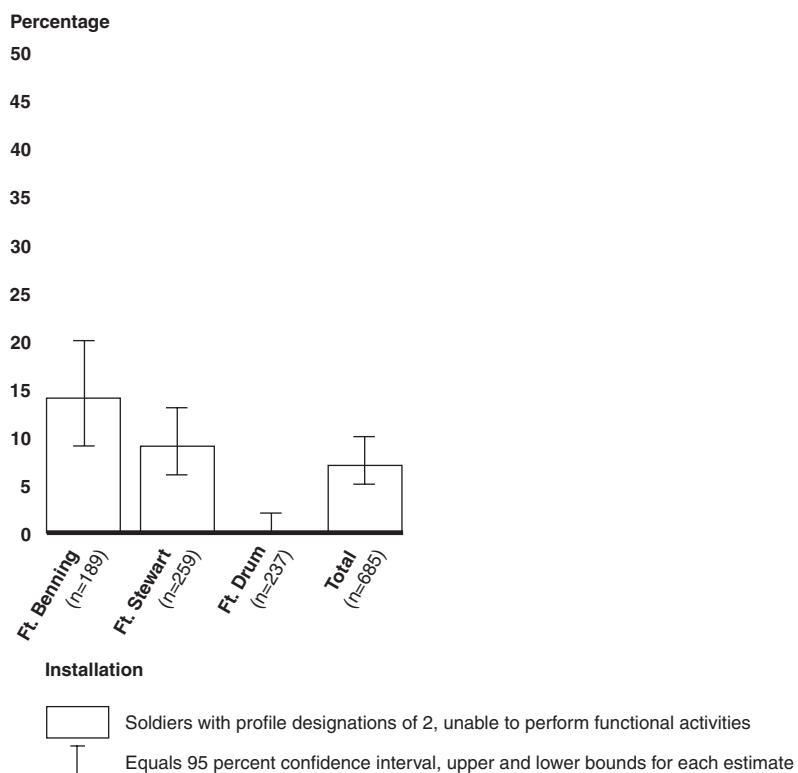
MEB, if needed, and would also provide it to the medical administrative office, to be retained in the medical record. Officials did not strictly adhere to time frames during this process, and personnel officials expressed doubt to us as to whether they received all physical profiles. Medical and command officials at Fort Drum stated that their process was also informal and they did not strictly adhere to timeframes, but they retained hard copies of all permanent physical profiles separate from the soldiers' medical records at the liaison officer's administrative office. Without a systematic method for approving and distributing profiles, current informal processes have led to inconsistencies in retention of the physical profiles in the medical record. The electronic personnel system also contains medical information, and we found that it is not being routinely updated. As a result, communication to commanders about physical limitations in many cases comes from the soldiers themselves, rather than the medical record system or personnel system.

Army officials intend to require that all physical profiles be processed and retained in the AHLTA electronic medical system; however, steps have not been taken to implement the system change. The system change will require that physical profiles be approved and routed electronically to commanders, medical providers, and the personnel offices to initiate MEB and MMRB proceedings. This change is intended to correct the limited visibility over profile information and inconsistencies in profile procedures, similar to the issues we have found in this review at Forts Benning, Stewart, and Drum. However, Army officials told us they have not finalized plans for actions needed and associated milestones to implement these changes. Moreover, current plans do not ensure that the information will be entered and distributed in a timely manner, as officials who convene the MMRB or MEB do not have authority to compel timely system input by commanders and medical providers.

Finally, the Army is not consistent in its use of numerical designations in profiles to reflect a soldier's ability to perform certain functional activities. Army guidance states that when soldiers are not able to meet certain requirements they are given a numerical designation of at least 3, and this designation should result, in most instances, in a review of their cases by an MMRB or MEB. When profiling officers prepare physical profiles carrying a designation of 2, these profiles do not generally receive further review, until the soldier indicates he or she is under a physical profile at the pre-deployment assessment. Based on our random projectable sample of soldiers preparing to deploy between April 2006 and March 2007, we estimate that about 7 percent of the soldiers who were preparing for deployment at Forts Benning, Stewart, and Drum had physical profiles in

their medical record showing the inability to perform functional activities yet were not designated with a score of at least 3.³¹ Figure 2 shows the estimated percentage (and confidence intervals) of soldiers by Army installation who had profiles that indicated that they were unable to perform certain functional activities, yet the profiles had a designation of 2.

Figure 2: Estimated Percentage of Soldiers Unable to Perform Functional Activities Yet Designated as 2 in Their Profiles



Source: GAO review of Army records.

The physical profile form defines performance of functional activities according to whether the soldier is: (1) able to carry and fire his or her individually assigned weapon; (2) able to move a fighting load of 48 pounds for at least 2 miles; (3) able to wear his or her protective mask and all chemical defense equipment; (4) able to construct an individual fighting

³¹The 95 percent confidence interval for this estimate is from 5 to 10 percent of soldiers.

position; (5) able to perform 3-5 second rushes under direct or indirect fire; and (6) healthy, without any medical condition that prevents deployment. Army regulation 40-501 allows for some flexibility in the medical provider's designation of numerical designation in a soldier's profile, and according to medical providers, they may upgrade designations based on their knowledge of the soldier's medical condition and the soldier's capacity to handle medical limitations. However, discretionary upgrades can mask a soldier's limitations such that a commander might deploy the soldier without benefit of MMRB evaluation and may place the soldier in duties unsuitable to his or her limitations.

We did not find widespread revision of profiles by profiling officers or approving authorities prior to deployment. Only 1 percent of the physical profiles we reviewed were changed from a permanent 3 to 2 within a few months prior to the soldier's deploying. Upgrades in numerical designations are generally annotated by remarks in the descriptive text included in a soldier's profile, and they must include a second approving medical provider's signature. However, informal discussions between soldier and medical provider can result in a change in the profile designation that may not be noted in the profile. In one case, we found that a soldier's profile was changed from a 3 to a 2 without meaningful annotation, and lacking the requisite second approving signature. This soldier reported to us that she had not undergone a new medical diagnosis prior to the profile upgrade; however, she also had told her medical provider that she did not want to go through an MMRB or MEB and thereby risk being removed from the Army. According to Army officials, soldiers' medical conditions may have improved for various reasons, such as undergoing surgery or additional physical therapy.

Although we found no evidence of widespread revision in numerical designations, in our surveys to deployed soldiers or our interviews with Army personnel officials and family members of deployed soldiers, some soldiers or family members expressed concerns to us that they were uninformed about how the Army was addressing their medical problems prior to deployment, and they knew of no venue to resolve their complaints. In surveys, two additional soldiers also stated that they did not feel they had been correctly graded in their physical profile designations, but were reluctant to discuss the matter with their commanding officers for fear of prejudicial treatment. One soldier stated that her physical profile had been changed without further physical examination. The other soldier noted that her physical profile designation was upgraded even though a medical provider had added more limitations after examining her, and she did not agree that the profile expressed all the limitations

caused by her back, knee, and shoulder ailments. We reviewed the documentation in the physical profiles of these soldiers and the profiles contained requisite approving signatures, dates, and descriptions of limitations. However, our analysis did not evaluate the medical providers' diagnoses of the medical conditions, because we are not qualified to evaluate the providers' medical judgment. Moreover, we would not be able to determine from the documentation if the soldier did not agree with the profile, whether the profile was changed without further physical examination, or whether the medical provider or the soldier fully communicated all of the issues involved.

Army personnel officials told us that they were unable to assist soldiers bringing complaints about not being evaluated by a medical board when the soldiers received a new permanent profile prior to their deployment, because the officials do not have access to soldiers' medical information and do not have the authority to enforce time frames. These officials had also been contacted by soldiers' family members who were concerned that the soldiers would be deployed and their conditions would worsen at deployed locations. An Army personnel official told us that soldiers sometimes questioned whether they were to be evaluated by a board prior to deployment, but by the time this official received the physical profile to initiate an MMRB, the soldiers had already been deployed. Because the officials do not have access to all medical information, they would not be able to verify whether soldiers' profiles were approved. These situations may be occurring because physical profiles are not being distributed in a timely manner. Also, because Army personnel officials do not have the authority to enforce time frames, they could not compel commanders to provide timely input for the approval of the profile or compel designated approving authorities to distribute the approved profiles. Thus, although Army personnel officials may believe that physical profiles are not being delivered in a timely manner, they do not have the ability to resolve these soldiers' complaints.

Issues regarding proper medical evaluation of soldiers prior to deployment could be resolved by having a designated point of contact to whom soldiers and family members can bring their concerns. Such a point person would require access to the soldier's medical information and the ability to resolve any problems and questions about a soldier's medical readiness. This person would also need to work independently of the operations commander in order to prevent bias or coercion by the commander in resolving soldier issues.

In September 2007, the Army Medical Command created a program to designate an ombudsman, or point of contact, available for each installation to whom soldiers can bring concerns on issues such as health care, pay, physical disability processing, and transition to the Veterans Administration. The Army memorandum³² establishing this program states that ombudsmen will resolve complaints, assist in obtaining accurate information, and act as advocates specifically for soldiers assigned to the Warrior Transition Unit and their families. According to ombudsmen at Forts Benning, Stewart, and Drum, they may also provide support for any soldier or family member of a soldier who needs assistance, through walk-ins or through the Army Wounded Soldier and Family Hotline. In accordance with the memorandum, the ombudsman will be independent from commanders at the installation, and will work closely with the Medical Assistance Group, which is part of the Army Medical Command under the Army Surgeon General's leadership at Fort Sam Houston, Texas. However, the ombudsman program is not broadly publicized as a resource for active duty soldiers with medical conditions or their family members. We were not able to fully evaluate how effectively the ombudsman program would be able to resolve the issues brought by deploying soldiers as opposed to soldiers in the Warrior Transition Unit and their family members, as the ombudsman program has only recently been implemented. It was not fully implemented at the time of our review at Forts Benning, Stewart, and Drum. Ensuring that soldiers who are not part of the Warrior Transition Unit and their family members are aware of and have access to the ombudsman program may help to alleviate some of these concerns brought forth by deploying soldiers.

As a result of the various medical record deficiencies and discretionary profile revisions discussed, commanders' visibility over their soldiers' potential medical conditions cannot be ensured. Furthermore, without a well-publicized ombudsman program, soldiers preparing for deployment cannot be assured of having the opportunity to air and resolve their medical concerns.

³² Army Office of the Surgeon General/Army Medical Command Policy Memorandum, *Ombudsman Program in Support of Warriors in Transition* (Sept. 6, 2007).

One In 10 Soldiers in the Projectable Sample Who Has a Medical Condition Has Deployed, but We Were Unable to Determine Duty Suitability

Based our review of medical records from Forts Benning, Stewart, and Drum, we estimate that about 10 percent of active duty soldiers with profiles indicating medical conditions that could require significant limitations in duty assignments were deployed to Iraq and Afghanistan. Although Army guidance allows for the deployment of soldiers with medical conditions, it requires commanders to assign soldiers to duties that are suitable to their limitations. Because of the low response rate to our survey, we were unable to determine the extent to which these soldiers were in fact assigned duties suitable to their medical conditions. From the limited responses to our survey and from interviews with soldiers, most reported that they were able to accomplish most of their duties, although they were sometimes required to perform duties exceeding their medical limitations.

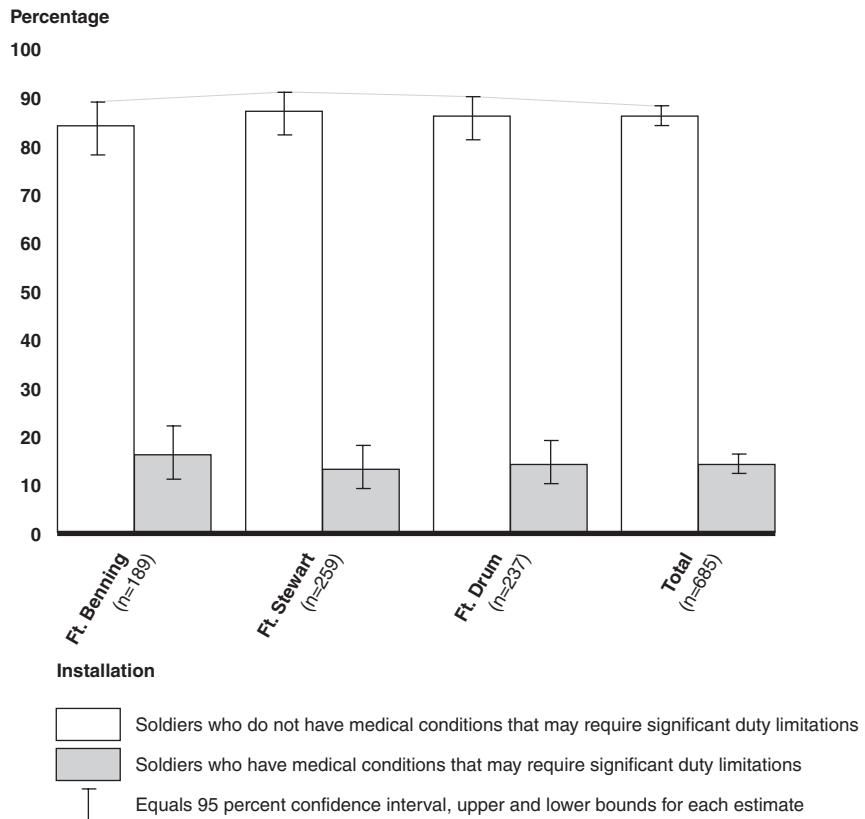
Some Deploying Soldiers Have Medical Conditions

We reviewed 685 medical records taken from a random projectable sample of active component soldiers who were preparing for deployment between April 2006 and March 2007 from Forts Benning and Stewart, in Georgia, and Fort Drum, in New York. From these installations, we estimate that 86 percent of soldiers, did not have profiles indicating medical conditions that could require significant limitations in duty assignments.³³ We estimate that 14 percent of soldiers preparing to deploy from Forts Benning, Stewart, and Drum had profiles indicating conditions that could require significant limitations: specifically, soldiers with physical profile designations of 3 or 4, or who indicated that they could not perform certain functional activities.³⁴ Figure 3 shows the total number of records reviewed and the estimated percentage (and confidence intervals) of soldiers who had medical impairments that could require significant limitations by installation from Forts Benning, Stewart, and Drum.

³³The 95 percent confidence interval for this estimate is from 84 to 88 percent of soldiers.

³⁴The 95 percent confidence interval for this estimate is from 12 to 16 percent of soldiers.

Figure 3: Comparison of Estimated Percentages of Soldiers with Profiles Who May Require Significant Duty Limitations against Those Who Do Not



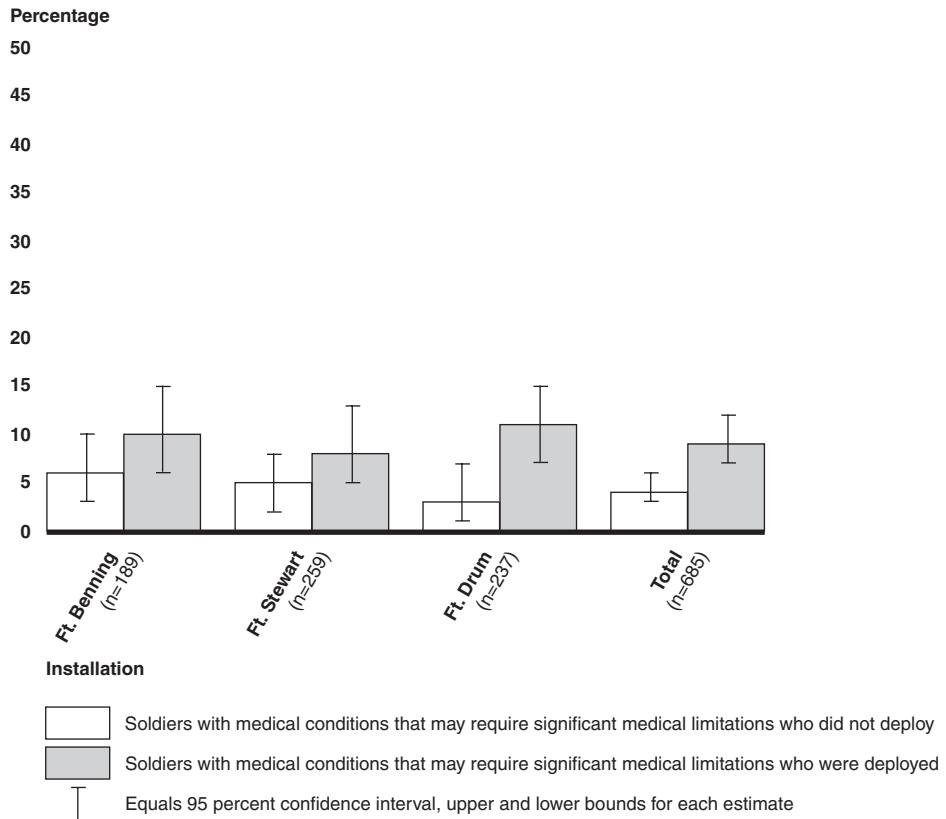
Source: GAO review of Army records.

As shown in figure 4, of the estimated 14 percent of soldiers preparing to deploy from Forts Benning, Stewart, and Drum who had medical conditions that could require significant limitations in duty assignment, approximately two-thirds—about an estimated 10 percent of the total number of soldiers³⁵—were deployed to Iraq or Afghanistan. These soldiers with medical conditions included soldiers having a physical profile designation of at least a 3, or indicating that they could not perform certain functional activities. The remaining estimated 4 percent of soldiers

³⁵The 95 percent confidence interval for this estimate is from 7 to 12 percent of soldiers.

with medical conditions that could require significant limitations did not deploy.³⁶

Figure 4: Comparison of Estimated Percentages of Soldiers Having Medical Conditions That May Require Significant Duty Limitations Who Deployed against Those Who Did Not



Source: GAO review of Army records.

Soldiers in the sample who deployed with medical conditions that could require significant limitations had conditions such as herniated discs, back pain, chronic knee pain, type 2 diabetes, or mild asthma. A soldier might have a physical profile that indicates multiple medical limitations that fall under different categories.³⁷ Table 2 shows that of the 66 deployed soldiers

³⁶The 95 percent confidence interval for this estimate is from 3 to 6 percent of soldiers.

³⁷See appendix III for descriptions of the physical profile categories.

who had medical conditions that could require significant limitations, 55 percent deployed with defects of the lower extremities (under the “L” category). For example, one soldier’s physical profile showed chronic hip pain that restricted physical training pace and limited the soldier to lifting no more than 48 pounds. Medical conditions of the eyes and psychiatric conditions had the lowest rates of occurrence. While we did not review documentation of medical limitations other than the soldiers’ physical profiles, according to Army medical officials, mental health conditions are not generally documented in physical profiles unless the conditions limited a soldier’s ability to accomplish his or her duty. Commanders were also notified of a soldier’s mental condition by medical providers if commanders requested the mental health evaluation of the soldier.

Table 2: Numbers and Percentages of Medical Conditions That May Require Significant Duty Limitations, by Physical Profile Category, across Profiles of Deployed Soldiers in the Sample

Category of medical conditions in physical profiles	Number of medical conditions	Percentage of medical conditions
“P” Physical Capacity	15	23%
“U” Upper Extremities	7	11%
“L” Lower Extremities	36	55%
“H” Hearing and Ears	10	15%
“E” Eyes	3	5%
“S” Psychiatric	2	3%

Source: GAO review of Army soldiers’ medical records.

Note: The 73 total occurrences of medical limitations in the sample were indicated in the physical profiles of 66 soldiers with medical conditions that may require significant limitations who were deployed to Iraq and Afghanistan. The percentages of occurrences do not equal 100 percent because some soldiers have a medical condition that may require significant limitations in more than one category.

Extent to Which Commanders Assigned Soldiers to Duties Suitable to Their Medical Conditions Cannot Be Determined

We were unable to determine the extent to which deployed soldiers in the sample with medical conditions were assigned duties suitable to their limitations. While Army guidance requires commanders to assign soldiers to duties that are suitable to their medical conditions, it does not require that they track the assignments of their soldiers to duties that accommodate their limitations. In order to determine the extent to which they had been assigned to duties suitable for those conditions, we surveyed by e-mail a sample of deployed soldiers with medical conditions. In our survey, we asked these soldiers for information on their ability to perform the duties to which they were assigned. However, we did not get a sufficiently high response rate to enable us to project findings from the survey respondents. We sent the survey to 66 soldiers, but received responses from only 24. Of the 24 soldiers who responded, 19 reported that they were able to complete most or all of their duties, and 22 of the 24 said they wanted to deploy with their units. None said that they could perform only a few or none of their duties. However, 5 of the soldiers we surveyed indicated that they were able to perform only some of their duties.

Survey responses indicated that some soldiers had experienced job reassignments to accommodate the limitations of their medical conditions. For example, one soldier had a shoulder injury that limited his ability to wear all of his body armor. When his unit was deployed to Iraq, he was assigned to duties in Kuwait so that he would not have to wear all of his body armor. Another soldier with a hearing deficit had his occupational category changed from infantry to supply specialist to protect him from exposure to loud noise. One soldier had degenerative disc disease, with lower back and leg pain, and his commander reassigned him from being leader of his unit to base security to accommodate his medical condition by limiting the time he had to wear his equipment. However, three of our survey respondents reported that their duties or occupational categories were not changed, although they believed they should have been. For example, one soldier often fell asleep during guard duty because his sleep apnea treatment was impaired by the irregularity of electric power availability, which he needed to support his continuous positive airway pressure machine.

Although we were unable to speak with the commanders of the particular soldiers surveyed in the sample, we spoke with other commanders at Forts Benning, Stewart, and Drum to help explain these survey responses. These commanders reported that they were aware of the medical conditions of the soldiers with whom they had deployed and that they always considered these conditions in their duty assignments. Army commanders

told us that soldiers with medical impairments may on occasion be required to perform job duties exceeding their limitations because they have special skills that are hard to replace using other personnel. Commanders may also sometimes assign soldiers to duties exceeding their limitations because they are unaware of the extent of the limitations, as soldiers' physical profiles may not reflect all of their medical information. Furthermore, according to both soldiers and senior medical officials whom we interviewed, soldiers may conceal the extent of their medical limitations or may negotiate with medical providers in order to remain with their units or in the Army. For example, one soldier did not agree with the upgrading of her physical profile designation, but also did not want to fully disclose her medical condition for fear of not meeting Army medical standards. Two soldiers stated that they agreed with their physical profile designation, which masks the severity of their limitations, and they were deployed although their medical condition was progressively worsening while at deployed locations. In both these cases, the soldiers stated that they were nearing retirement and did not want to be discharged from the Army due to a medical board evaluation before they were eligible to receive their full retirement pensions, and they confirmed that their commanders accommodated their medical conditions.

Conversely, Army officials have stated that soldiers may overstate their medical conditions in order to avoid deployment and they must take into account their other experiences with the soldiers' limitations when evaluating their medical deployability. For example, one commander told us that one soldier brought up a foot injury to delay her deployment, although it was diagnosed by a medical provider outside the military and it was not in her military medical record. The commander allowed the soldier time to recuperate and allowed her to purchase a specific type of boot to accommodate her injury. However, when the soldier did not purchase the boots in a timely manner in order to further delay her deployment, the commander found the boots at a nearby supply store and deployed the soldier into theater.

Although we were not able to determine the extent to which Army commanders have assigned soldiers to duties that are suitable for their limitations, there may be soldiers who had proper evaluations performed prior to deployment yet still have concerns about the suitability of their assigned duties. Soldiers should have access to a program at deployed locations that is similar to the ombudsman program available at Army installations. The soldiers who have medical conditions that develop or worsen while at deployed locations and may not believe they are assigned to appropriate duties should have access to a contact person who can

address their concerns. This person should have access to the soldier's medical information and the authority to resolve any problems, and he or she should work independently from the soldier's commander.

Conclusions

Long-standing issues regarding the medical deployability of servicemembers have become increasingly important as the Global War on Terrorism continues and large numbers of servicemembers are deployed. The Army is hampered by its lack of an enforcement mechanism from ensuring that soldiers' MMRB or MEB evaluations are conducted within prescribed time frames and not delayed by the failure of commanders or medical providers to provide required information on time. Of the 6 percent of soldiers from Forts Benning, Stewart, and Drum that we estimate were deployed with medical conditions that required further evaluation by a MMRB or MEB, we estimate that 3 percent of these soldiers did not receive these needed evaluations prior to deployment. Furthermore, the commanders and medical providers who must make medical readiness and deployment decisions about soldiers do not always have full visibility over the soldiers' medical limitations because physical profile documentation is not always properly retained or complete. The Army intends to establish centralized electronic documentation and distribution of physical profiles to improve visibility, but it has not finalized plans for needed actions, associated milestones, and timeliness of the process. Without timely MMRB or MEB evaluations and the retention of complete physical profile information for deploying soldiers with medical conditions, commanders who assign duties can not be fully informed of soldiers' medical limitations. We did not find widespread cases of improper duty assignments for deployed soldiers with medical conditions; however, the weaknesses in the Army procedures could permit this to occur. Although the Army ombudsman program may help alleviate concerns from soldiers and family members, they should be made aware of the program and the program should be made available for soldiers prior to and during deployment. Unless soldiers have been fully evaluated, have an independent contact person to promote their concerns, and commanders have full knowledge of the soldiers' limitations, the Army cannot safeguard soldiers with medical conditions from being deployed and assigned to duties unsuitable for their limitations.

Recommendations for Executive Action

To safeguard soldiers with significant medical limitations from being deployed and assigned to duties unsuitable for their limitations, we recommend that the Secretary of the Army:

1. direct the Office of the Army Surgeon General and the Army Deputy Chief of Staff G-1 to collaboratively develop an enforcement mechanism to ensure that medical providers and commanders follow procedures so that soldiers whose permanent physical profiles indicate significant medical limitations are properly referred to and complete MEB and MMRB evaluation boards prior to deployment;
2. direct the Office of the Army Surgeon General and the Army Deputy Chief of Staff G-1 to move forward with plans to electronically process and retain physical profiles, including specific actions and milestones, and to implement guidance to help ensure
 - the timely distribution of profiles to commanders and the military personnel office and
 - that the medical record keeping system include all information in the approved physical profiles, and that all profiles be retained in soldiers' medical records;
3. direct the Army Human Resources Command to disseminate information and provide soldiers and their families access to an independent ombudsman program prior to and during deployment to ensure that they are fully informed about this resource for addressing their concerns and to add independent oversight of Army medical and deployment processes in the interests of the soldiers.

Agency Comments and Our Evaluation

DOD provided written comments on a draft of this report and concurred with each of our recommendations. In commenting on our first recommendation, DOD stated that our findings do not suggest the existence of a widespread problem throughout the Army, as the number of soldiers in our sample deployed without appearing before a medical evaluation board was 17; and furthermore, that survey and interview responses indicate that commanders appear to be assigning soldiers with medical limitations to suitable duties. However, we note that the 17 soldiers who deployed without receiving proper board evaluations represent a sizeable proportion of the 42 soldiers in our sample who should have received such a review prior to deployment. These 17 soldiers, furthermore, can be projected from our sample to represent approximately 3 percent of the soldiers who were preparing for deployment at the three installations; we are providing further clarification

regarding this figure in the body of this report. Furthermore, as we have noted in our report, ad hoc measures to assign soldiers to suitable duties are not as reliable as an enforcement mechanism for ensuring that soldiers are so assigned. While we could not determine the number of soldiers who may have been assigned to unsuitable duties, as the Army does not track this information and our survey responses were limited, neither could we confirm that soldiers with medical limitations were consistently assigned to suitable duties.

DOD noted that it had actions planned or underway to conduct a thorough inspection of the policies and procedures supporting a commander's determination of soldier deployability, and to release new guidance regarding medical conditions that should preclude affected servicemembers from deployment, along with other initiatives, and we commend these efforts.

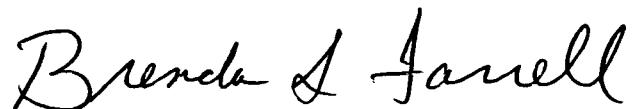
In commenting on our second recommendation, DOD stated that the Office of the Army Surgeon General has identified and submitted requirements for the automation of physical profiles, beginning development by the end of 2008, and we commend this planned initiative. We note that it is important for these plans to have specific actions and milestones, and for the Army to implement guidance to ensure timely distribution of profiles to commanders and military personnel officials through the automated system.

In commenting on our third recommendation, DOD stated that two programs, the Army Ombudsman Program and the Wounded Soldier and Family Hotline, are available to assist all soldiers (and their families) whether preparing to deploy, deployed, or redeploying. However, we note that the Wounded Soldier and Family Hotline does not constitute a resource independent of the command. Although DOD states that retribution is not tolerated against those using the hotline, we maintain our view that soldiers should be able to turn to a resource independent of the command. With regard to the Ombudsman Program, though it is independent of the command, we continue to assert our view that broad advertisement is needed for soldiers and their families to be made aware of this resource for those soldiers not only returning from deployment, but also prior to and during deployment.

The Army's comments are reprinted in appendix VI. In addition, the Army provided technical comments, which we have incorporated as appropriate.

We are sending copies of this report to interested congressional committees; the Secretary of Defense; the Secretaries of the Army, the Navy, and the Air Force; and the Commandant of the Marine Corps. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions concerning this report, please contact me at (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VII.

A handwritten signature in black ink that reads "Brenda S. Farrell". The signature is fluid and cursive, with "Brenda" on the first line and "S. Farrell" on the second line.

Brenda S. Farrell, Director
Defense Capabilities and Management

Appendix I: Scope and Methodology

To address the extent to which the Army is adhering to its medical and deployment requirements regarding decisions to send soldiers with medical limitations to Iraq and Afghanistan, we reviewed relevant DOD and Army guidance related to medical standards and deployment procedures. We discussed the deployment of servicemembers with medical conditions with a variety of officials from the Office of the Assistant Secretary of Defense for Health Affairs, the Department of the Army, and the Office of the Army Surgeon General. As agreed with congressional staff, we also met with the Offices of the Air Force and Navy Surgeons General as well as the Navy Bureau of Medicine and Surgery to gain an understanding of those services' guidance on medical standards and deployment procedures. In December 2007, we provided a briefing to congressional staff that included a discussion of these services' guidance regarding deployment of servicemembers with medical conditions.

In addition, we reviewed Army guidance covering documentation of soldiers' medical limitations prior to deployment and conditions under which soldiers with medical conditions are considered deployable. We reviewed a sample of medical records and interviewed medical providers, Army commanders, and soldiers at selected installations to identify and evaluate installation procedures for documenting medical limitations and training provided regarding this issue at each installation.

We selected three Army installations—Fort Benning, Fort Stewart, and Fort Drum. We selected Fort Stewart and Fort Drum based on the number of active component soldiers deployed from each installation to Iraq or Afghanistan between April 1, 2006, and March 31, 2007; and we selected Fort Benning based on initial allegations of active component soldiers being deployed with significant medical limitations from this installation.

For our medical records review, we selected random samples of active component soldiers at Fort Benning, Fort Stewart, and Fort Drum. In order to create the sample, we used the universe of soldiers from each installation who were preparing for deployment from April 1, 2006, to March 31, 2007, to Iraq or Afghanistan and answered "yes" to question number 3 on the pre-deployment health assessment (form DD 2795)¹ which asks, "Are you currently on a profile, or light duty, or are you undergoing a medical board?" Our statistical samples are representative of soldiers at these installations who meet our eligibility criteria. Those who

¹See appendix V for a copy of the pre-deployment health assessment form 2795.

did not complete a pre-deployment health assessment during this time frame had no chance of being selected. Of the soldiers preparing to deploy, soldiers may have their deployment delayed or may ultimately not be deployed for various reasons, such as not completing required training and not having proper security clearances for deployment, as well as not meeting medical readiness standards.

For various reasons, medical records were not always available for review. Therefore, we reviewed more medical records than our target sample size on the assumption we might not meet our desired precision. Specifically, there were seven reasons identified for not being able to physically secure soldiers' medical records for review:

1. **Charged to patient.** When a patient visits a clinic (on-post or off-post), the medical record is physically given to the patient. The procedure is that the medical record will be returned by the patient following their clinic visit.
2. **Charged out to Medical Evaluation Board.** Soldier is in the process of a medical review board and their medical record is retained by the board members.
3. **Charged out to Physical Evaluation Board.** Soldier is in the process of a physical review board and their medical record is retained by the board members.
4. **Expired term of service.** Soldier separates from the Army and their medical record is sent to the Veterans Administration Records Management Center St. Louis, Missouri.
5. **Record is missing and not accounted for by the medical records department.** No tracking sheet is in the file system to indicate the patient has checked it out or otherwise.
6. **Permanent change of station.** Soldier is still in the Army, but has transferred to another installation. The medical record was sent to the new installation with the soldier.
7. **Temporary duty off site.** Soldier has left the Army installation, but is expected to return. The temporary duty is long enough to warrant that the medical record accompany the soldier. (Note: In the sample, there were no cases for which the soldier was on temporary duty off site.)

The sample size for our medical record review was determined to provide a 95 percent confidence interval for an attribute measure with a precision of at least 5 percent. Because we followed a probability procedure based on random selections, the sample is only one of a large number of samples that we might have drawn. Since each sample could have provided different estimates, we express our confidence in the precision of our particular sample's results as a 95 percent confidence interval (e.g., plus or minus 5 percentage points). This is the interval that would contain the actual population value for 5 percent of the samples we could have drawn. As a result, we are 95 percent confident that each of the confidence intervals will include the true values in the study population. At two of the three installations we visited, we reviewed more records than needed to meet our target sample size because medical officials made available more medical records than our targeted sample amount. The number of soldiers in the samples and the total records reviewed of soldiers at the installations visited are shown in table 3.

Table 3: Soldier Sample Universe, Target Sample Sizes, and Number of Records Reviewed at Each Visited Installation

Installation	Number of soldiers who fit the criteria for the sample (universe)	Target sample sizes	Total records reviewed
Fort Benning	336	180	189
Fort Stewart	794	259	259
Fort Drum	552	227	237
Total	1682	666	685

Source: GAO analysis of Army soldiers' records.

At each location, we examined medical documentation for evidence of physical profiles (form DA 3349)² that were created between April 2001 and March 2007. We selected this time frame because it would include any profile in effect when a soldier in the sample deployed. We reviewed both hard copy soldier medical records for evidence of physical profiles as well as any profiles located in Armed Forces Health Longitudinal Technology Application (AHLTA), the department of defense's electronic medical record. In addition, we requested that installation medical personnel provide any information on profiles from the Army's Medical Protection System (MEDPROS) for each of the soldiers in the sample to ensure that

²See appendix II for a copy of the Army physical profile form 3349.

our review of medical records was complete and that we identified all physical profiles. Even though MEDPROS is not an official medical record, it is used in the determination of medical readiness in preparation for deployment and contains medical limitation information and dates of physical profiles. After gathering all physical profiles, we reviewed them for completeness, and analyzed them to determine if they were completed in accordance with Army guidance. From the soldiers that received a physical profile between April 2001 and March 2007, we identified the subset of soldiers with medical conditions that may require significant medical limitations, specifically soldiers with permanent or temporary profile designation of at least a 3, or a designation of 2 showing inability to do certain functional activities. We did not review documentation of medical limitations other than the physical profiles. According to Army officials, mental health conditions are not generally documented in physical profiles unless the conditions limited a soldier's ability to accomplish his or her duty. Commanders were also notified of their soldiers' mental conditions by medical providers if they requested a mental health evaluation of the soldiers.

Although we have taken many steps to ensure accurate data analysis of active component soldiers with a physical profile, previous GAO reviews have found that Army medical records do not contain all medical documentation as required, thus, our review may not encompass the full extent of soldiers with physical profiles.

To determine the extent to which the Army is deploying soldiers to Iraq and Afghanistan with medical conditions requiring duty limitations, and whether it is assigning them to duties suitable to their limitations, we requested deployment data on the subset of soldiers who we identified as having a significant medical limitation from the time period of April 2001 to March 2007. We then compared data from our medical record review at Forts Stewart, Benning, and Drum to deployment data for soldiers in the sample provided by Army officials to identify soldiers with a medical condition that may require significant limitations who had deployed to Iraq or Afghanistan. We reviewed Army processes for tracking soldiers while deployed. We interviewed Army officials including commanders and medical providers about established procedures in place to ensure soldiers are assigned within their limitations. We also surveyed by e-mail 66 soldiers we identified who had deployed with medical conditions to Iraq and Afghanistan. We received responses from 24 of these soldiers, for a response rate of about 36 percent. These responses do not allow us to project the extent to which deployed soldiers with medical conditions across the Army were assigned to duties suitable to their medical

limitations in Iraq and Afghanistan; nevertheless, we present the information we obtained to illustrate these issues.

We conducted this performance audit from April 2007 through April 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Army Physical Profile (DA Form 3349)

PHYSICAL PROFILE									
For use of this form, see AR 40-501; the proponent agency is the Office of the Surgeon General.									
1. MEDICAL CONDITION: (Description in lay terminology) <input type="checkbox"/> INJURY? Or <input type="checkbox"/> ILLNESS/DISEASE?				2. CODES (Table 7-2 AR 40-501)		3. P U L H E S			
						Temporary			
						Permanent			
4. PROFILE TYPE									
a. TEMPORARY PROFILE (Expiration date YYYYMMDD) (Limited to 3 months duration)									
b. PERMANENT PROFILE (Reviewed and validated as a minimum with every periodic physical exam or after 6 years from the date of issue)									
c. IF A PERMANENT PROFILE WITH A 3 OR 4 PULHES, DOES THE SOLDIER MEET RETENTION STANDARDS IAW CHAPTER 3 AR 40-5017 (IF USAF/ARNG/AMGUS SOLDIER NOT ON ACTIVE DUTY SEE PARA. 8-10 & 10-26, AR 40-501 IF SOLDIER DOES NOT MEET RETENTION STANDARDS.) Needs MHRS Needs MED/PEB									
5. FUNCTIONAL ACTIVITIES FOR PERMANENT AND TEMPORARY PROFILES (If any answer (a-f) is NO then the profile should be at least a 3)									
a. ABLE TO CARRY AND FIRE INDIVIDUAL ASSIGNED WEAPON									
b. ABLE TO MOVE WITH A FIGHTING LOAD AT LEAST 2 MILES (48 LBS. Includes helmet, boots, uniform, LBE, weapon, protective mask, pack, etc.)									
c. ABLE TO WEAR PROTECTIVE MASK AND ALL CHEMICAL DEFENSE EQUIPMENT									
d. ABLE TO CONSTRUCT AN INDIVIDUAL FIGHTING POSITION (Dug, fill, & lift sand bags, etc.)									
e. ABLE TO DO 3-5 SECOND RUSHES UNDER DIRECT AND INDIRECT FIRE									
f. IS SOLDIER HEALTHY WITHOUT ANY MEDICAL CONDITION THAT PREVENTS DEPLOYMENT?									
6. APFT		YES	NO	ALTERNATE APFT (Fill out if unable to do APFT run otherwise N/A)					
2 MILE RUN				APFT WALK N/A					
APFT SIT-UPS				APFT SWIM N/A					
APFT PUSH UPS				APFT BIKE N/A					
7. STANDARD OR MODIFIED AEROBIC CONDITIONING ACTIVITIES (Check all applicable boxes)									
UNLIMITED RUNNING		OR RUN AT OWN PACE & DISTANCE							
UNLIMITED WALKING		OR WALK AT OWN PACE & DISTANCE							
UNLIMITED BIKING		OR BIKE AT OWN PACE & DISTANCE							
UNLIMITED SWIMMING		OR SWIM AT OWN PACE & DISTANCE							
8. UPPER BODY WEIGHT TRAINING (See FM 21-20)		9. LOWER BODY WEIGHT TRAINING (See FM 21-20)							
10. OTHER: e.g. Functional limitations and capabilities and other comments: (May continue on page 2)									
11. THESE PARAMETERS ARE OPTIONAL, USE AS NEEDED									
Lifting or carrying max weight _____ or _____ distance									
Running maximum distance _____									
Prolonged standing - maximum time per episode _____									
Marching with standard field gear except rucksack max distance _____									
Impact activities such as jumping max # reps in one day _____									
This temporary profile is an extension of a temporary profile first issued on _____									
12. TYPE NAME & GRADE OF PROFILING OFFICER 13. SIGNATURE 14. DATE (YYYYMMDD)									
15. ACTION BY APPROVING AUTHORITY 16. TYPE NAME & GRADE OF SENIOR PROFILING OFFICER OR APPROVING AUTHORITY 17. SIGNATURE 18. DATE (YYYYMMDD)									
19. ACTION BY UNIT COMMANDER (See para 7-12, AR 40-501) 20. COMMENT									
THIS PROFILE REQUIRES A CHANGE IN THIS SOLDIER'S MOS OR DUTY ASSIGNMENT									
If this is a permanent profile with a PULHES serial of 3 or 4 refer to block 4c									
21. TYPE NAME & GRADE OF UNIT COMMANDER 22. SIGNATURE 23. DATE (YYYYMMDD)									
24. PATIENT'S IDENTIFICATION (For typed or written entries give: Name (Last, first); grade; SSN; hospital or medical facility) 25. UNIT 26. ISSUING CLINIC, PROVIDER E-MAIL & PHONE NUMBER									
PROFILING OFFICER (Or Approving Authority if applicable) IS RESPONSIBLE FOR ENSURING THE PULHES & DATE OF PROFILE IS ENTERED INTO MEDPROS. ORIGINAL COPY POSTED IN MEDICAL RECORDS, 1 COPY TO UNIT COMMANDER, 1 COPY GIVEN TO SOLDIER, 1 COPY TO MILPO.									
DA FORM 3349, FEB 2004 DA FORM 3349, MAY 86, IS OBSOLETE.									
Page 1 of 2 AFD 091.020									

Appendix II: Army Physical Profile (DA Form 3349)

PHYSICAL PROFILE - PAGE 2 (OPTIONAL)	
PATIENT'S NAME	DATE (YYYYMMDD)
CONTINUATION (From page 1, Item 10)	

DA FORM 3349, FEB 2004

Page 2 of 2
AFD 9V1.020

Source: U.S. Army

Appendix III: PULHES Definitions

Category definitions

P—Physical Capacity or Stamina	Normally includes conditions of the heart; respiratory system; gastrointestinal system, genitourinary system; nervous system; allergic, endocrine, metabolic and nutritional diseases; diseases of the blood and blood forming tissues; dental conditions; diseases of the breast, and other organic defects and diseases that do not fall under other specific factors of the system.
U—Upper Extremities	Concerns the hands, arms, shoulder girdle, and upper spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.
L—Lower Extremities	Refers to the feet, legs, pelvic girdle, lower back musculature and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.
H—Hearing and Ears	Relates to auditory acuity and disease and defects of the ear.
E—Eyes	Centers on visual acuity and diseases and defects of the eye.
S—Psychiatric	Concerns personality, emotional stability, and psychiatric diseases.

Source: Army Regulation 40-501.

Profile numerical designations

Numerical	Designation definitions
1	Indicates a high level of medical fitness.
2	Refers to some medical condition or physical defect that may require some activity limitations.
3	Signifies one or more medical conditions or physical defects that may require significant limitations. The individual should receive assignments commensurate with his or her physical capability for military duty.
4	Indicates one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited.

Source: Army Regulation 40-501.

Appendix IV: Army Physical Profile Codes

Code	Description/assignment limitation	Medical criteria (examples)
CODE A	No assignment limitation.	No demonstrable anatomical or physiological impairment within standards established in table 7-1.
CODE B	May have assignment limitations that are intended to protect against further physical damage/injury. May have minor impairments under one or more PULHES factors that disqualify for certain MOS training or assignment.	Minimal loss of joint motion, visual and hearing loss
CODES C through P*	Possesses impairments that limit functions or assignments. The codes listed below are for military personnel administrative purposes. Corresponding limitations are general guidelines and are not to be taken as verbatim limitations. (For example, a Soldier with a code C may not be able to run but may have no restrictions on marching or standing.) Item 3 of DA Form 3349 will contain the specific limitations.	
CODE C	Limitations in running, marching, standing for long periods etc.	Orthopedic or neurological conditions
CODE D	Limitations in any type of strenuous physical activity.	Organic cardiac disease; pulmonary insufficiency
CODE E	Limitations requiring dietary restrictions preventing consumption of combat rations.	Endocrine disorders—recent or repeated peptic ulcer activity—chronic gastrointestinal disease requiring dietary management.
CODE F	Limitations prohibiting assignment or deployment to OCONUS areas where definitive medical care is not available.	Individuals who require continued medical supervision with hospitalization or frequent outpatient visits for serious illness or injury.
CODE G	Limitations prohibiting wearing Kevlar, LBE, lifting heavy materials required of the MOS, overhead work.	Arthritis of the neck or joints of the extremities with restricted motion; disk disease; recurrent shoulder dislocation.
CODE H	Limitations on duty where sudden loss of consciousness would be dangerous to self or to others such as work on scaffolding, vehicle driving, or near moving machinery.	Seizure disorders; other disorders producing syncopal attacks of severe vertigo, such as Ménierè's syndrome.

Code	Description/assignment limitation	Medical criteria (examples)
CODE J	<p>Given known handicaps associated with high frequency hearing loss similar to this, Commanders are highly recommended to make an individual risk assessment of any Soldier with hearing loss that might be tasked to perform duties that require good hearing, for example; localization and detection of friend or foe sounds, scout, point, sentry, forward listening, post/observer, radio/telephone operator, and so forth. (See DA Pam 40-501, Chapter 2-4, Combat Readiness Effects.) Hearing Protection Measures required to prevent further hearing loss.</p> <ol style="list-style-type: none"> 1. No exposure to noise in excess of 85 dBA (decibels measured on the A scale) or weapon firing without use of properly fitted hearing protection. Annual hearing test required. 2. Further exposure to noise is hazardous to health. No duty or assignment to noise levels in excess of 85 dBA or weapon firing (not to include firing for preparation of replacements for overseas movement qualification or annual weapons qualification with proper ear protection). Annual hearing test required. 3. No exposure to noise in excess of 85 dBA or weapon firing without use of properly fitted hearing protection. This individual is 'deaf' in one ear. Any permanent hearing loss in the good ear will cause a serious handicap. Annual Hearing test required. 4. Further duty requiring exposure to high intensity noise is hazardous to health. No duty or assignment to noise levels in excess of 85 dBA or weapon firing (not to include firing for overseas movement or weapon firing without use of properly ear protection). No duty requiring acute hearing. A hearing aid must be worn to meet medical fitness standards. 	Susceptibility to acoustic trauma.
CODE L	Limitations restricting assignment to cold climates.	Documented history of cold injury; vascular insufficiency; collagen disease, with vascular or skin manifestations.
CODE M	Limitations restricting exposure to high environmental temperature.	History of heat stroke; history of skin malignancy or other chronic skin diseases that are aggravated by sunlight or high environmental temperature.
CODE N	Limitations restricting wearing of combat boots.	Any vascular or skin condition of the feet or legs that, when aggravated by continuous wear of combat boots, tends to develop unfitting ulcers.
CODE P	Limitations restricting wearing or being exposed to required items necessary to perform duty (for example, Latex, wool).	Established allergy to wool, latex.
CODE T*	WAIVER granted for a disqualifying medical condition/standard for initial enlistment or appointment. The disqualifying medical condition/standard for which a waiver was granted will be documented in the Soldier's accession medical examination.	
CODE U	Limitation not otherwise described, to be considered individually. (Briefly define limitation in item 8.)	Any significant functional assignment limitation not specifically identified elsewhere.

Appendix IV: Army Physical Profile Codes

Code	Description/assignment limitation	Medical criteria (examples)
CODE V*	Deployment. This code identifies a Soldier with restrictions on deployment. Specific restrictions are noted in the medical record.	
CODE W*	MMRB. This code identifies a Soldier with a permanent profile who has been returned to duty by an MMRB (MOS Medical Review Board.)	
CODE X*	This code identifies a Soldier who is allowed to continue in the military service with a disease, injury, or medical defect that is below medical retention standards, pursuant to a waiver of retention standards under chapter 9 or 10 of this publication, or waiver of unfit finding and continued on active duty or in active Reserve status under AR 635-40.	
CODE Y*	Fit for duty. This code identifies the case of a Soldier who has been determined to be fit for duty (not entitled to separation or retirement because of physical disability) after complete processing under AR 635-40.	

Source: Army Regulation 40-501.

Notes: (1) Profile codes are indicated under item 2 of the physical profile form for all permanent physical profiles. (2) Codes do not automatically correspond to a specific numerical designation of the profile but are based on the general physical/assignment limitations.

*The Army regulation does not provide medical criteria for these codes.

Appendix V: Department of Defense Pre-Deployment Health Assessment (DD Form 2795)

Appendix V: Department of Defense Pre-Deployment Health Assessment (DD Form 2795)

  33823

PLEASE FILL IN SOCIAL SECURITY # - -

Health Assessment

1. Would you say your health in general is: Excellent Very Good Good Fair Poor

2. Do you have any medical or dental problems? Yes No

3. Are you currently on a profile, or light duty, or are you undergoing a medical board? Yes No

4. Are you pregnant? (FEMALES ONLY) Don't Know Yes No

5. Do you have a 90-day supply of your prescription medication or birth control pills? N/A Yes No

6. Do you have two pairs of prescription glasses (if worn) and any other personal medical equipment? N/A Yes No

7. During the past year, have you sought counseling or care for your mental health? Yes No

8. Do you currently have any questions or concerns about your health? Yes No

Please list your concerns: _____

Service Member Signature _____

I certify that responses on this form are true.

Pre-Deployment Health Provider Review (For Health Provider Use Only)

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

GI
 GU
 Cardiac
 GYN
 Combat / Operational Stress Reaction
 Mental Health
 Dental
 Neurologic
 Dermatologic
 Orthopedic
 ENT
 Pregnancy
 Eye
 Pulmonary
 Family Problems
 Other _____

FINAL MEDICAL DISPOSITION: Deployable Not Deployable

Comments: (If not deployable, explain)

I certify that this review process has been completed.
Provider's signature and stamp:

Date (dd/mm/yyyy) / /

End of Health Review

33823

DD FORM 2795, MAY 1999 ASD (HA) APPROVED SEPTEMBER 1998 Ver 1.3

Source: U.S. Army

Appendix VI: Comments from the Department of Defense

REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE DEPUTY CHIEF OF STAFF, G-1
300 ARMY PENTAGON
WASHINGTON DC 20310-0300

Director of Military
Personnel Management

Ms. Brenda S. Farrell
Director, Defense Capabilities and Management
U.S. Government Accountability Office
Washington, D.C. 20548

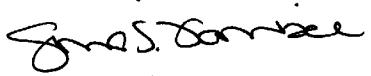
Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office Draft Report, "MILITARY PERSONNEL: Army Needs to Better Enforce Requirements and Improve Recordkeeping for Soldiers Whose Medical Conditions May Call for Significant Duty Limitations," dated May 9, 2008 (GAO Code 351152; GAO-08-546).

The Department appreciates the opportunity to comment on the draft report. We greatly value GAO's efforts in examining this important and complex issue. As written, the Department agrees with the GAO report and its recommendations. Detailed comments to each of GAO's recommendations are enclosed.

As you may be aware, the Secretary of the Army has directed the Army Inspector General to conduct a broad and thorough inspection of these same issues. The results of this inspection will validate our new initiatives that we are instituting which will help adequately address your cited concerns and recommendations.

Sincerely,


Gina S. Farrisee
Brigadier General, U.S. Army
Director of Military
Personnel Management

**GAO DRAFT REPORT - DATED MAY 9, 2008
GAO CODE 351152/GAO-08-546**

**“MILITARY PERSONNEL: Army Needs to Better Enforce
Requirements and Improve Recordkeeping for Soldiers Whose Medical
Conditions May Call for Significant Duty Limitations”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE RECOMMENDATIONS**

RECOMMENDATION 1: The GAO recommends that the Secretary of the Army direct the Office of the Army Surgeon General and the Army Deputy Chief of Staff G-1 to collaboratively develop an enforcement mechanism to ensure commanders and medical providers follow procedures to make sure Soldiers whose permanent physical profiles indicate significant medical limitations are properly referred to and complete MMRB and MEB evaluation boards prior to deployment. (pg. 34/GAO Draft Report)

DOD RESPONSE:

DoD concurs. However, the findings of the GAO report do not suggest a widespread problem throughout the Army and commanders appear to be adhering to the current procedures regarding the medical fitness of Soldiers identified to deploy. A sample taken from Forts Benning, Stewart, and Drum, showed a total of 17 Soldiers found with a P3 or higher profile who had not appeared before a medical evaluation board and had deployed. The report could not confirm that these Soldiers, who deployed from these installations, had not been assigned to duties suitable to their medical condition. Survey and interview responses indicate that Soldiers generally felt they had been assigned to suitable duties and commanders reported they were aware of deployed Soldiers' medical conditions and these conditions had been taken into account when assigning duties.

In addition, the Secretary of the Army recently directed that the Inspector General conduct a thorough inspection of the medical policies and procedures that support a commander's determination of Soldier deployability. The inspection will occur over several months including both CONUS and OCONUS units and agencies. Also, the Assistant Secretary of Defense for Health Affairs is planning to release new guidance, as mentioned in the GAO report, providing more guidelines on medical conditions that should preclude affected service members from being deployed.

The Army and DoD are in the process of instituting a number of initiatives to improve the process for completion of permanent physical profiles and referral to an MMRB or MEB, if medically indicated. Physical profile information must be entered into the Medical Protection System (MEDPROS) which tracks all immunization, medical readiness, and deployability data for Soldiers in order to assist the chain of command in determining their medical and dental readiness. The Army's Periodic Health Assessment (PHA) policy requires that Soldiers' physical profiles be reviewed by privileged

providers on an annual basis. Once the profile process is automated, the enforcement mechanism will be accomplished using the interplay between MEDPROS and the Medical Nondeployable Module already in use in the Reserve Component (United States Army Reserve and National Guard). The effort to automate this interplay will result in a program referred to as EProfile. The program highlights Soldiers without correct profile codes (Box 2 on the DA 3349) indicating MMRB or MEB board completion. Where codes are missing, Soldiers will be categorized as nondeployable and unit commanders will be alerted. Once the physical profile is fully automated, the MEB or MMRB referral process will be generated automatically (built into the logic of the program). Until then, it is the responsibility of the hospital commander to educate and enforce compliance with MEB/MMRB referral and profile routing requirements. The MEDCOM Commander allows hospital commanders to determine which management strategies work best for their organization.

In addition, DoD and the Department of Veterans Affairs are reevaluating the complete Physical Disability Evaluation Process which includes the Medical Evaluation Board (MEB). The intent is to streamline the process and return the Soldier to duty or determine his/her disability. For the first quarter of FY08, the Department of the Army average processing time for an MEB was 40 days, with the goal being 30 days.

RECOMMENDATION 2: The GAO recommends that the Secretary of the Army direct the Office of the Army Surgeon General and the Army Deputy Chief of Staff G-1 to move forward with plans to electronically process and retain physical profiles, including specific actions and milestones, and to implement guidance to help ensure the timely distribution of profiles to commanders and the military personnel office and that the medical recordkeeping system include all information in the approved physical profiles and that all profiles be retained in Soldiers' medical records. (pg. 34/GAO Draft Report)

DOD RESPONSE:

DoD Concurs. The Office of the Army Surgeon General identified and submitted the functional requirements for the automation of physical profiles for Defense Business Transformation Certification. This DoD mandated business certification is expected in July 2008 with appropriate funds obligated for development in the fourth quarter of FY08.

Current requirements for processing and distributing paper copies of profiles are addressed in AR 40-501, chapter 7. One copy is forwarded to the unit commander, one copy to the installation Military Personnel Office, one copy is given to the Soldier, and one copy is retained in the medical record. Methods of distribution vary based on installation resources and support. Provider generated profile information is also recorded in the military's electronic health record or AHLTA (Armed Forces Health Longitudinal Technology Application). Profile information in AHLTA is not yet available to unit commanders; however, the automated physical profile is designed to correct this deficiency. Paper copies of profiles continue to be maintained in existing paper-based medical records.

RECOMMENDATION 3: The GAO recommends that the Secretary of the Army direct the Army Human Resources Command to disseminate information and provide Soldiers and their Families access to an independent ombudsman program prior to and during deployment to ensure they are fully informed about this resource for addressing their concerns and to add independent oversight of Army medical and deployment processes in the interests of the Soldiers. (pg. 34/GAO Draft Report)

DOD RESPONSE:

DoD concurs with the concerns expressed in the above recommendation; however, these concerns can be addressed using an existing Army program. In 2007, the Army established two programs to assist wounded or ill Soldiers and their Family members: The Wounded Soldier and Family Hotline and an Ombudsman Program. The Wounded Soldier and Family Hotline in particular, could effectively address GAO's concerns and assist all Soldiers (and Families), whether preparing to deploy, deployed, or redeployed. The Army senior leadership supports the use of the existing Hotline and Ombudsman programs, as they already serve as independent resources for addressing Soldier and Family member concerns.

In March 2007, Army senior leadership established the Wounded Soldier Family Hotline, the purpose of which was two-fold: To offer wounded, injured, or ill Soldiers and their Family members a way to seek help to resolve medical issues and to provide an information channel of Soldier medical related issues directly to Army senior leadership to enable them to improve the way the Army serves the medical needs of Soldiers and their Families. The hotline was not established to circumvent the chain of command, but rather to give Soldiers and Family members an additional means to resolve medical-related issues and navigate through the medical care system. Retribution directed towards those who use the hotline is not tolerated. The hotline is managed and operated by the U.S. Army Human Resources Command in Alexandria, VA. Since inception, the hotline has fielded more than 12,000 calls, involving approximately 3000 issues. The WSFH addresses issues for all components, Veterans, and Retirees. All callers' issues are captured and addressed; we have not turned a caller away. Callers' issues are staffed to the organization which can best resolve the issue which includes the appropriate Army Commands, Army Service Component Commands, or Direct Reporting Units for resolution and follow-up within three business days. The hotline operates 24 hours a day, seven days a week. It is staffed by 11 Soldiers, 34 Contractors and one DA Civilian. Many of the Contractors are either former Soldiers or Family members of current or formerly serving Soldiers. The Army Wounded Soldier and Family Hotline can be accessed by phone (1-800-984-8523 or DSN 312-328-0002) or email (wsfsupport@conus.army.mil).

In April 2007, the Army established an Ombudsman Program to serve Soldiers and Family members assigned to Warrior Transition Units (WTUs). Ombudsman work as advocates to resolve issues related to health care, physical disability processing, Reserve Component medical retention issues, transition to the Veterans Administration, pay issues, and more. Ombudsman link Soldiers and Family members with the appropriate individual and/or agency that can fully address their concerns or questions. There are

currently 48 Ombudsman supporting 29 sites and two more will soon be added to Germany supporting two additional sites. To date, this program has assisted over 5,400 Soldiers. Ombudsman work directly for the Army Medical Command (MEDCOM) and are independent from local commands and all information between the Soldier and Ombudsman are confidential in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While the majority of cases are opened directly by the Ombudsman on site, the MEDCOM Medical Assistance Group works closely with the Wounded Soldier Family Hotline to resolve any WTU medical issues called into the hotline.

The Army in 2008 is entering its seventh year of persistent conflict. Many wounded and injured Soldiers, who have supported the Global War on Terror, as well as their Families, are enduring hardships in navigating our medical care system. Our Army is committed to providing outstanding medical care for the men and women who have volunteered to serve this great nation. Recent events at Walter Reed Army Medical Center made it clear the Army needs to revise how it meets the needs of our wounded and injured Soldiers and their Families. Part of the response by Army senior leaders was the creation of the two programs mentioned. The Army Wounded Soldier and Family Hotline is poised to assist all wounded, injured or ill Soldiers and their Family members regardless of whether the Soldier has already deployed, is currently deployed, or preparing to deploy. As a matter of fact, the hotline is already receiving calls from Soldiers who are deployed, and from their Families. The Army will continue to aggressively advertise the availability of this critical resource and established metrics will continue to be reported to Army senior leaders.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Brenda S. Farrell, (202) 512-3604 or farrellb@gao.gov.

Acknowledgments

In addition to the contact named above, Marilyn Wasleski, Assistant Director; Gina Hoffman; LaToya King; Grace Materon; Elisha Matvay; Sonya Phillips; Jeanett Reid; Norris Smith III; and Cheryl Weissman made significant contributions to the report. In addition, Terry Richardson, Carl Barden, and Steven Putansu provided guidance and assistance with design and analysis; Nicole Harms provided legal advice; Steve Fox, Marcia Crosse, and Tom Conahan advised on message preparation; and Clara Mejstrik, Adam Smith, Maria Storts, and John Wren provided assistance during medical file reviews.

Related GAO Products

DOD Civilian Personnel: Medical Policies for Deployed DOD Federal Civilians and Associated Compensation for Those Deployed. GAO-07-1235T. Washington, D.C.: September 18, 2007.

Defense Health Care: Comprehensive Oversight Framework Needed to Help Ensure Effective Implementation of a Deployment Health Quality Assurance Program. GAO-07-831. Washington, D.C.: June 22, 2007.

DOD Civilian Personnel: Greater Oversight and Quality Assurance Needed to Ensure Force Health Protection and Surveillance for Those Deployed. GAO-06-1085. Washington, D.C.: September 29, 2006.

Military Personnel: DOD and the Services Need to Take Additional Steps to Improve Mobilization Data for the Reserve Components. GAO-06-1068. Washington, D.C.: September 20, 2006.

Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members. GAO-06-362. Washington, D.C.: March 31, 2006.

Military Personnel: Top Management Attention Is Needed to Address Long-standing Problems with Determining Medical and Physical Fitness of the Reserve Force. GAO-06-105. Washington, D.C.: October 27, 2005.

Defense Health Care: Improvements Needed in Occupational and Environmental Health Surveillance during Deployments to Address Immediate and Long-term Health Issues. GAO-05-632. Washington, D.C.: July 14, 2005.

Defense Health Care: Force Health Protection and Surveillance Policy Compliance Was Mixed, but Appears Better for Recent Deployments. GAO-05-120. Washington, D.C.: November 12, 2004.

Military Personnel: DOD Needs to Address Long-term Reserve Force Availability and Related Mobilization and Demobilization Issues. GAO-04-1031. Washington, D.C.: September 15, 2004.

Defense Health Care: DOD Needs to Improve Force Health Protection and Surveillance Processes. GAO-04-158T. Washington, D.C.: October 16, 2003.

Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance. GAO-03-1041. Washington, D.C.: September 19, 2003.

Military Personnel: DOD Needs More Data to Address Financial and Health Care Issues Affecting Reservists. GAO-03-1004. Washington, D.C.: September 10, 2003.

Defense Health Care: Army Has Not Consistently Assessed the Health Status of Early-Deploying Reservists. GAO-03-997T. Washington, D.C.: July 9, 2003.

Defense Health Care: Army Needs to Assess the Health Status of All Early-Deploying Reservists. GAO-03-437. Washington, D.C.: April 15, 2003.

VA And Defense Health Care: Military Medical Surveillance Policies in Place, but Implementation Challenges Remain. GAO-02-478T. Washington, D.C.: February 27, 2002.

Gulf War Illnesses: Research, Clinical Monitoring, and Medical Surveillance. GAO/T-NSIAD-98-88. Washington, D.C.: February 5, 1998.

Gulf War Illnesses: Improved Monitoring of Clinical Progress and Reexamination of Research Emphasis Are Needed. GAO/NSIAD-97-163. Washington, D.C.: June 23, 1997.

Defense Health Care: Medical Surveillance Improved Since Gulf War, but Mixed Results in Bosnia. GAO/NSIAD-97-136. Washington, D.C.: May 13, 1997.

Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards. GAO/NSIAD-94-36. Washington, D.C.: March 23, 1994.

Operation Desert Storm: War Highlights Need to Address Problem of Nondeployable Personnel. GAO/NSIAD-92-208. Washington, D.C.: August 31, 1992.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "E-mail Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, DC 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@gao.gov, (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548